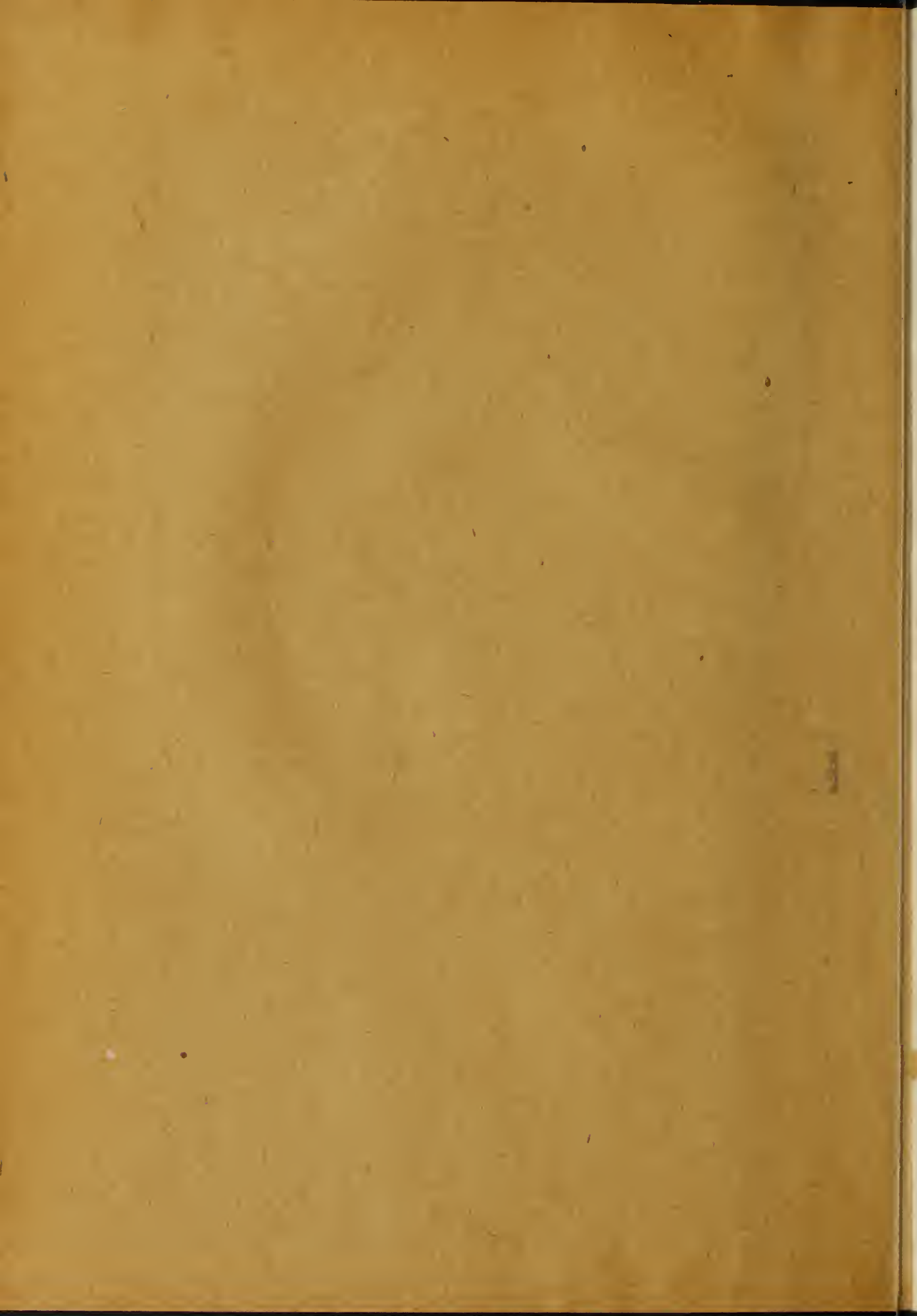


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The Journal of the South Carolina Medical Association

JANUARY, 1946

VOL. XLII, NO. 1

CONTENTS

Article	Author	Page
"A History of the Case" in Franklin D. Roosevelt's Own Words		1
Primary Cysts of the Omentum	D. L. Maguire, M.D. A. J. Buist, M.D.	2
The Use of Curare (Introcstrin) in Reducing Convulsive Effects of Tetanus	Charles B. Hanna, M.D.	5
Editorials — The Ten Point Program — Deaths — Public Health News — News Items		

BACKGROUND

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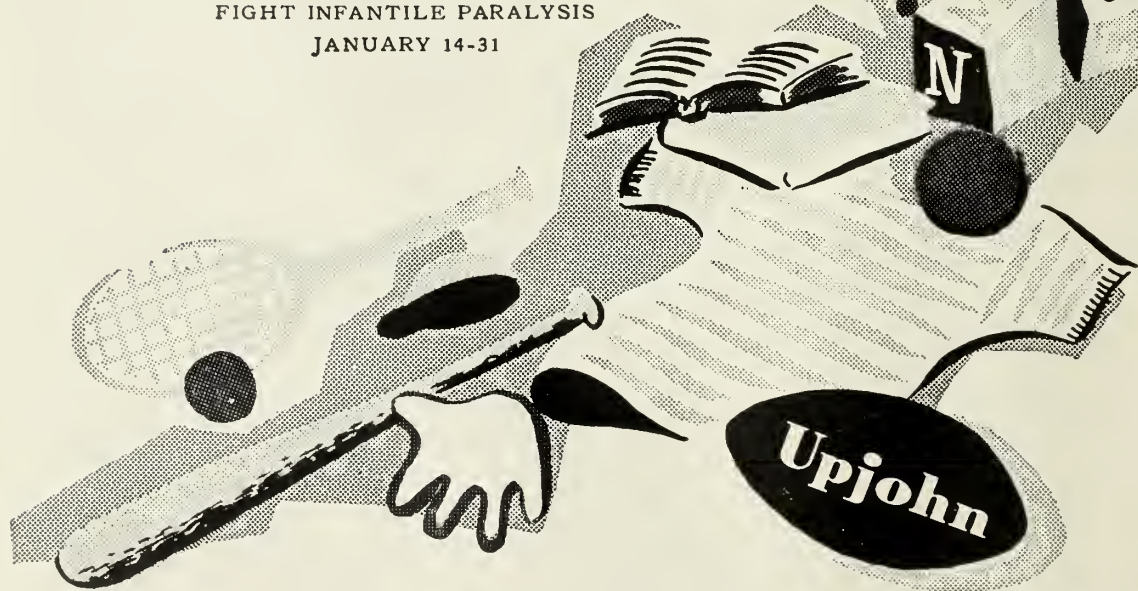
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1. Am. J. Dis. Child. 66:1 (July) 1943.

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Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879. Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918.

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

January, 1946

NUMBER 1

“A History of the Case” in Franklin D. Roosevelt’s Own Words

(Copyright 1946, by Mrs. William Egleston)

(It is our privilege to present a letter which we believe will become one of the famous “Case Reports” of history. Written to the late Dr. William Egleston of Hartsville, S. C., it is now in the possession of Mrs. William Egleston and is published with her permission.)

It is particularly appropriate that it be published during the month of January—the month of the late President Roosevelt’s birth and the month which is now associated in the minds of all Americans with the March of Dimes. Editor.)

Warm Springs, Georgia
October 11, 1924

My dear Dr. Egleston:

Please excuse my delay in replying to your letter which has been forwarded to me down here in your neighboring state where I am spending a few weeks swimming and getting sunlight for my legs.

I am very glad to tell you what I can in regard to my case and as I have talked it over with a great many doctors can, I think, give you a history of the case which would be equal to theirs.

First symptoms of the illness appeared in August, 1921, when I was thoroughly tired from overwork. I first had a chill in the evening which lasted practically all night. The following morning the muscles of the right knee appeared weak and by afternoon I was unable to support my weight on my right leg. That evening the left knee began to weaken also and by the following morning I was unable to stand up. This was accompanied by a continuing temperature of about 102 and I felt thoroughly achy all over. By the end of the third day practically all muscles from the chest down were involved. Above the chest the only symptom was a weakening of the two large thumb muscles making it impossible to write. There was no special pain along the spine and no rigidity of the neck.

For the following two weeks I had to be catheter-

ized and there was slight, though not severe, difficulty in controlling the bowels. The fever lasted for only 6 or 7 days, but all the muscles from the hips down were extremely sensitive to the touch and I had to have the knees supported by pillows. This condition of extreme discomfort lasted about 3 weeks. I was then moved to a New York hospital and finally moved home in November, being able by that time to sit up in a wheel chair, but the leg muscles remained extremely sensitive and this sensitiveness disappeared gradually over a period of 6 months, the last remaining point being the calf muscles.

As to treatment—the mistake was made for the first 10 days of giving my feet and lower legs rather heavy massage. This was stopped by Dr. Lovett of Boston who was, without doubt, the greatest specialist on infantile paralysis. In January, 1922, 5 months after the attack he found that the muscles behind the knees had contracted and that there was a tendency to foot-drop in the right foot. These were corrected by the use of plaster casts during two weeks. In February, 1922, braces were fitted on each leg from the hips to the shoes, and I was able to stand up and learned gradually to walk with crutches. At the same time gentle exercises were begun, first every other day, then daily, exercising each muscle 10 times and seeking to avoid any undue strain by giving each muscle the correct movement with gravity. These exercises I did on a board placed on the bed.

The recovery of muscle paralysis began at this time, though for many months it seemed to make little progress. In the summer of 1922 I began swimming and found that this exercise seemed better adapted than any other because all weight was removed from the legs and I was able to move the legs in the water far better than I had expected. Since that time, i.e., for the last two years, I have as far as possible in connection with my work and other duties, carried out practically the same treatment with the

result that the muscles have increased in power to a remarkable extent and the improvement in the past 6 months has been even more rapid than at any previous time.

I still wear braces, of course, because the quadriceps are not yet strong enough to bear my weight. One year ago I was able to stand in fresh water without braces when the water was up to my chin. Six months ago I could stand in water up to the top of my shoulders and today can stand in water just level with my arm pits. This is a very simple method for me of determining how fast the quadriceps are coming back. Aside from these muscles the waist muscles on the right side are still weak and the outside muscles on the right leg have strengthened so much more than the inside muscles that they pull my right foot outward. I continue corrective exercises for all the muscles.

To sum up I would give you the following "Don'ts":

Don't use heavy massage but use light massage rubbing always towards the heart.

Don't let the patient over-exercise any muscle or get tired.

Don't let the patient feel cold, especially the legs, feet or any other part affected. Progress stops entirely when the legs or feet are cold.

Don't let the patient get too fat.

The following treatment is so far the best judging from my own experience and that of hundreds of other cases which I have studied

1. Gentle exercise especially for the muscles which seem to be worst affected.

2. Gentle skin rubbing—not muscle kneading—bearing in mind that good circulation is a prime requisite.
3. Swimming in warm water—lots of it.
4. Sunlight—all the patient can get, especially direct sunlight on the affected parts. It would be ideal to lie in the sun all day with nothing on. This is difficult to accomplish but the nearest approach to it is a bathing suit.
5. Belief on the patient's part that the muscles are coming back and will eventually regain recovery of the affected parts. There are cases known in Norway where adults have taken the disease and not been able to walk until after a lapse of 10 or even 12 years.

I hope that your patient has not got a very severe case. They all differ, of course, in the degree in which the parts are affected. If braces are necessary there is a man in New York, whose name I will send you if you wish when I get back to New York, who makes remarkable light braces of duraluminum. My first braces of steel weighed 7 lbs. apiece—my new ones weigh only 4 lbs. apiece. Remember that braces are only for the convenience of the patient in getting around—a leg in a brace does not have a chance for muscle development. This muscle development must come through exercise when the brace is not on—such as swimming, etc.

I trust that your own daughter is wholly well again.

Very truly yours,

Franklin D. Roosevelt.

William Egleston, M.D.

Hartsville, S. C.

Primary Cysts of the Omentum

D. L. MAGUIRE, M.D.

A. J. BUIST, M.D.

Charleston, S. C.

Primary cysts of the omentum occur so infrequently that observation of a case is worth reporting, and especially is this so in as much as the average surgeon will not come across more than one in a lifetime. An idea of their infrequent occurrence may be gained from the fact that the first recorded report was that of Gairdner in 1852, who described to The Pathological Society of London a serous omental cyst which he had discovered at autopsy. No reports of similar cysts are to be found in the English literature for thirty years, at the end of which time Bantock reported a similar cyst which he had noted on abdominal operation. Further examination of the literature reveals an excellent article by Dowd, who at the time of the writing of the article several decades later could find but 37 reported cases of omental cysts.

A very clear description of the condition with careful scrutiny of all reported cases was made by Horgan in 1935, the number of cases found in the literature having increased to put 97 at this time. At the Jewish Hospital in Brooklyn, N. Y., Borger could find but three cases in the records of the institution, these records representing the surgery performed on all patients over a period of 29 years. At the Mayo Clinic, the records reveal 14 primary omental cysts found between 1911 and 1938, of which 11 were small in size and noted only as incidental autopsy findings. As we all know, mesenteric cysts are relatively infrequently noted. And yet, the records of those men reporting on both conditions give a relative frequency of from 3 to 1 to 10-1 between mesenteric and omental cysts. There have been almost 114,000

admissions to the Roper Hospital with no record of a primary omental cyst, nor can a record on any be obtained from the Department of Pathology.

There are several interesting factors to be noted on studying the reported cases. The great majority of these cysts occur in the early years of life. According to Horgan, 35 per cent occur in the first decade, and 68 per cent are to be found before the individuals reach 30 years of age. Race apparently plays no part in the frequency of occurrence, for they have been noted with equal frequency in both the white and colored races. Strange as it may seem, all men reporting cases agree with the observation that the condition is to be found more often among females than among males. Horgan, in his collected series of 97 cases, found the ratio to be 40 to 60 per cent, or three to two, but others in smaller series have reported the ratio to be as high as 3 to 1.

Omental cysts may be secondarily associated with many conditions, of which dermoid cysts, foreign bodies, parasites, and malignant degeneration are examples. When the result of, or associated with such conditions, cysts of the omentum are not nearly so infrequent as is the primary type of cyst with which this paper deals. The exact etiology of the type under discussion is not known, but several hypotheses concerning its origin have been offered. Such factors as trauma to the omentum, hemorrhage into the omentum, endothelial hyperplasia, chronic inflammation resulting in lymphatic blocking, and embryonic cell rests have been suggested as factors which would explain the origin of these cysts. The fact that many of these cysts contain blood, either in the form of recent or old blood pigment, has caused some to believe that hemorrhage from unknown causes may be a factor. Others, pointing to the high percentage of these cysts to be found in children and the still higher percentage to be found in young adults, believe that the condition can be accounted for as the result of cell rests which for reasons unknown begin to proliferate shortly after birth or in the early years of life. The majority of the writers appear to hold to the view that the condition is the result of some factor or factors producing interference with the normal lymphatic drainage from the omentum. Perhaps, this view is best presented by Montgomery and Wolman who in an article published in 1935 concluded from the fact that since hyperplasia and hypertrophy of the endothelial elements is almost constantly to be found in the cysts, that they are in reality cystic lymphangiomas which result from inflammatory irritation. This inflammation is of course a fore runner to the cyst, and may be the result of any of the multitudinous factors that may produce an inflammatory process.

Grossly, these cysts may vary in size from those accidentally discovered at autopsy to those of relative or actual enormous size, as was the one to be presented in this paper. 67 per cent of these cysts are single, but they may be multiple or they may be multiloculated. They are usually found freely mov-

able in the abdominal cavity, but several have been noted which have been densely adherent to adjacent or contiguous organs. The content of the cyst is thin and watery in consistence and varies in color from that of recent or old blood to a straw colored fluid.

The symptoms produced by these cysts are protean in their manifestations. The onset of the condition is insidious and the growth of the tumor is, as a rule, slow. However, if hemorrhage occurs into the cyst, its size may rapidly increase, and the symptomatology may become acute. A similar condition may present itself if sudden twisting or torsion of the cyst should occur, the symptoms now presenting themselves being those of the acute surgical abdomen. The usual picture presented, however, is that of any slow growing abdominal tumor; namely, such pressure manifestations as nausea, vomiting, vague abdominal distress, fullness, constipation or diarrhea, dysuria, frequency of urination, and eructation of gas. The outstanding symptoms noted in almost every case are a sense of fullness and weight in the abdomen and pain in varying degree. If hemorrhage has been associated with the cyst, a varying degree of secondary anemia may be noted.

The preoperative diagnosis of primary omental cyst is practically impossible to make with any certainty, due first, to the infrequency with which the condition is encountered, and secondly, to the many similar appearing conditions from which it must be differentiated. Ascites, ovarian cysts, mesenteric cysts, cystic tumors of the kidney, retroperitoneal cyst, tubercular peritonitis, and pancreatic cysts are a few of the most easily confused conditions, and it is obvious that in most cases of omental cyst a differential diagnosis would be an impossibility. In the case to be presented the writers, preoperative diagnosis was ovarian cyst, probably a malignancy.

The treatment of primary omental cysts is, of course, surgical, with complete removal of the cyst wall. If the cyst cannot be delivered in toto, its content should first be aspirated, after which delivery should be simple. As stated before, the entire cyst wall should be removed and as much of the omentum should be preserved as possible. Care should be observed in not destroying the blood supply to the remainder of the omentum or to the transverse colon.

Report of a Case

This white female, age 17 months, was admitted to St. Francis X. Hospital on April 22, 1940.

C. C. Mother states that this child was delivered normally and apparently developed normally until the age of three (3) months, at which time she had an "Internal Hemorrhage", no blood was passed by mouth or rectum. The child's abdomen became swollen and the child became very weak. A paracentesis was performed by a private physician in Greenville, S. C. and blood was removed from the peritoneal cavity. The abdomen never returned to normal size. However, the child appeared to im-

prove. During the past several months the abdomen has progressively increased in size. The child is able to walk and play (the mother also states that the child occasionally topples over, this is recent). Takes milk, cereals, etc. well.

There was no history of hematemesis or blood in the stools. Child has two (2) normal bowel movements daily. Appears to be comfortable most of the time.

No history of other illnesses, except for an occasional cold. (Child appears to have a cold at present).

Physical Examination:

Ears, Eyes, Nose and Mouth appear grossly negative.

Chest: Symmetrical, equal expansion.

Lungs: Clear to percussion and auscultation.

Heart: Rapid rate, but regular and sounds of good quality. No murmurs heard.

Abdomen: Extremely distended; dull to percussion and fluid wave elicited. No organs or masses palpable.

Laboratory Report:

Urinalysis grossly negative except for an occasional pus and blood.

Hemoglobin 50%

W. B. C. 6,650

Polynuclear 53%

Lymphocytes 44%

Large Mononuclears 1%

X-Ray Report (April 22):

Examination of abdomen, by plain film and barium enema, fluoroscopic and radiographic:

Plain film of abdomen gives no differentiation which is of value in diagnosis. A barium enema filled the colon for a distance of about eight inches. This portion was probably descending colon and sigmoid and is displaced to the midline of the body. I think this examination shows definitely that there is no megacolon, but otherwise no information is gotten.

Temperature, Pulse, and Respiration on admission:

T - 99 by rectum, P - 120, R - 26

On afternoon of April 22nd, an abdominal paracentesis was done under local anesthesia. Approximately five (5) ounces of dark chocolate fluid was removed. Flow was not free. Stopped most of the time. Apparently something would stop the flow from the inside.

Specimen of fluid sent to laboratory. Report read as follows:

Chemical test for blood-----Four plus

Microscopic test for blood-----Four plus

Bile test -----Negative

On afternoon of April 23rd, one day later, another paracentesis was performed. Thirty-two (32) ounces of dark chocolate fluid was removed. Specimen of this fluid was sent to Dr. Mood's laboratory for culture for T. B. June 12th, Report from culture, "Fluid from peritoneal cavity for T. B. negative."

April 25th. Upper abdomen tympanitic. Lower

abdomen dull. Dr. Wythe Rhett called in consultation.

April 25th. Rectal examination by Dr. Maguire. "Apparently no pressure on rectal wall as high as finger can reach. No bulging." After consultation, an exploratory laparotomy as advised.

Patient appears to have Bronchitis, coughing frequently, and free nasal discharge. Temperature slightly elevated. Temp. 100.8 by rectum on third day, this being the highest since admission. Pulse and respiration rather rapid. Patient was allowed to return home until Bronchitis is better.

May 4th. Patient was re-admitted for blood transfusion and preparatory treatment to operation. 238 c.c. whole blood was given under Ether Anesthetic on May 5th. Patient was allowed to return home again (May 6th). Surgery seemed inadvisable due to upper respiratory infection.

Laboratory report at this time was: Urine, grossly negative.

Hemoglobin -----53% (increase of 3% since last admission)

W. B. C. -----8,650 (slight increase over last)

Polynuclear ----- 46%

Lymphocytes ----- 48%

Large Mononuclears - 2%

Basophiles ----- 2%

Transitional ----- 2%

July 16th. Patient re-admitted. 210 c.c. whole blood given under Ether Anesthetic. Hbg. 83%; W.B.C. 14,100; Polys. 80; Lymph. 18; Mono. 2 July 17th. Laparotomy performed.

Findings: (Gross)—"Tremendously enlarged abdomen. Large multilocular cyst occupying about two-thirds (2/3) of abdominal cavity. Apparently pedicle of cyst attached to gastro-colic omentum, just under the greater curvature of stomach. Other abdominal organs appeared and felt normal."

What was done: Right paramedian incision, later enlarged, above umbilicus. Abdomen opened, cyst identified and delivered. Origin found to be attached to gastro-colic omentum. All adhesions severed and ligated. Impossible to dissect free all the sac wall because of intimate contact with intestine at one area. Pedicle doubly ligated. All bleeding points ligated. Abdomen closed in layers. Preoperative Diagnosis: Abdominal Cyst, Character, Origin (undetermined)

Postoperative Diagnosis: Cyst of Omentum.

Pathological Diagnosis: Serious Cysts of Omentum.

Pathological Report: "Received a large piece of stringy omentum, in one end of which there is a large imperfectly loculated cyst, previously opened, whose exterior is covered by fibro-fatty tissue and whose lining is grey and glistening. There are also several smaller cystic cavities present, some of which contain bloody fluid on section. Also a soft grey nodule containing firm tissue.

"Apparently serous type of cysts into which hemorrhage has occurred, with pigment and cholesterol

in the debris. The wall is composed of fibrous tissue, rather cellular, disposed in circular coat. The lining is completely missing and the wall fuses with the content which is composed of coagulum, granular debris and blood, partially decomposed, in which are large members of long slits, more or less characteristic of cholesterol."

March 20, 1941: The child made an uneventful

recovery, being discharged on 12th day postoperative. She has remained perfectly well, with no complaints, and no further enlargements of the abdomen.

July 15, 1945 (5 years after). Patient was seen and has developed to a normal well nourished child—with no evidence of any recurrence.

The Use of Curare (Introcosterin) in Reducing Convulsive Effects of Tetanus

Charles B. Hanna, M.D.
Roper Hospital, Charleston, S. C.

In the management of the convulsions of tetanus, the use of short acting anesthetics, such as avertin and the newer barbiturates has made it possible to save some of those patients who would have otherwise died. Spaeth¹ considers that such active sedation used along with usual procedures has reduced mortality to 35% as against a mortality of 65% with older methods. His report based on an extensive survey of experience at the Cook County Hospital is one of the more favorable estimates of the value of active sedation. There are recognizable limitations, however, to the use of these depressant drugs and there are obvious reasons to continue the search for drugs which offer still further improvement in the technic of convulsion control. The drug curare, acting primarily to block conduction of impulses from nerve to muscle, has been tried at intervals for a great many years. Results have not entirely established the value of this drug. The more recent availability of a stable, standardized form of curare under the trade name, Introcosterin, has increased interest in the revival of this drug, and there have been some exceptionally favorable reports, notably that by Cullen.^{2,3} His report indicates that Introcosterin can be given safely in installments for several days without cumulative toxic effects and the usual administration of Introcosterin as an adjuvant to anesthesia is considered a safe procedure. Isacson and Swenson⁴ are in general agreement with Cullen. On the other hand Perlstein and Weinglass,⁵ working with dogs, obtained results which they attributed to a cumulative toxic effect on the heart. Various features of their article, such as the failure to give weights of their animals when quoting dosages, serve to introduce some doubt as to the extent to which their objections should be recognized. Until more positive evidence is produced as to cumulative toxic effects when the drug is given as in tetanus, it would seem that Introcosterin might well be given a trial, at least in cases which are so severe as to respond unsatisfactorily to barbiturates. That was the situation in the case reported here, and although the patient finally expired, the improvement which followed the use of

Introcosterin was marked, and since this improvement continued for a day and a half, the results in this case were considered to favor further trial of the drug. CASE REPORT: CASE #38643

A 14-year old colored girl 10 days before had broken off a dirty splinter of wood in her right forearm. At that time she removed a portion of this splinter but was not certain that there was not some splinter left. No local treatment was administered then; nor had she received any tetanus antitoxin before or since. Her arm continued to be tender and painful. She first noticed her neck was progressively becoming stiffer since three days before admission. Her neck had become more and more hyperextended and stiff but not painful. Two days before admission her back and abdomen became stiff. On admission she was able to walk in a hesitant, stiff, awkward manner. She described her face as being tight. There had been difficulty in swallowing for the previous 24 hours but she could talk without difficulty. Except for anxiety she was fairly comfortable. PHYSICAL EXAMINATION showed a temperature of 100.4 degrees F., pulse 148, respiratory rate 28 and blood pressure 124/78. The patient was a well nourished and developed, acutely ill young negress of about 130 pounds body weight. There was moderate opisthotonus and the facial muscles were in constant spasm, producing the classical risus sardonicus. She was alert and could answer questions without difficulty although unable to open her mouth beyond mid-position. The skin was warm and slightly moist. The pupils were equal in size, round and reacted normally. The fundi were negative. The teeth could be separated little more than 1 cm. The neck was dorsiflexed, resistant to passive flexion but neither tender nor painful. Respiration was chiefly diaphragmatic. Except for tachycardia the heart was negative. The abdomen was slightly protuberant, tense with generalized muscle spasm due to opisthotonic position; with no pain or tenderness and active peristalsis. There was moderate spasm of all muscles and markedly hyperactive reflexes. The lumbar spine was in moderate opisthotonus. On the

right forearm was a hard, freely movable, tender ulcer with all local signs of an active infection. The right elbow could not be extended fully due to the local muscle spasm.

ACCESSORY CLINICAL FINDINGS: RBC—4,800,000 cu. mm.; Hemoglobin—12 gms., Haden-Hausser; WBC—8,100 cu. mm. with 89% polymorphonuclears and 11% lymphocytes; and a negative blood Wasserman. The urine had a specific gravity of 1.021 with one plus albumin.

Sedation was begun immediately. Sodium pentobarbital (5 grains) was given intramuscularly followed by a retention enema of paraldehyde (8 drams in 150 cc. of water). 100,000 units of tetanus antitoxin was given in 500 cc. 5% glucose in normal saline followed later with 80,000 units more intravenously. In hope of preventing complications such as bronchial pneumonia, 25,000 units of penicillin every 4 hours was given intramuscularly to a total of 250,000 units. Because of continued restlessness and trismus, sodium pentobarbital (2½ grains) was given intermittently for the first 24 hours.

Complete excision of the splinter site was done within the first two hours. 20,000 units of tetanus antitoxin was injected in the site of the excision. The pathological report showed an embedded splinter with a granulating tract into the dermis with scattered foreign body giant cells. No culture was taken.

On the second hospital day parenteral fluids were continued to 3000 cc. daily. Because of increasing drowsiness in the presence of continued muscle spasms, the time between doses of sodium pentobarbital was changed from 4 to 6 hours. The barbiturate seemed to depress the central nervous system without giving important muscle relaxation. There was such excessive flow of saliva, which the patient could neither expel nor swallow, that atropine sulfate (1/150 grain) was given every 8 hours and the foot of the bed was elevated for postural drainage. At the close of the day the temperature had reached 104 degrees F. and there were scattered coarse rales throughout both lung fields. In the hope of preventing pneumonia, sodium sulfadiazine (45 grains) was intravenously followed in 3 hours with 30 grains and then 15 grains every 4 hours intravenously.

The third hospital day the patient was in a more critical condition and had almost constant muscle spasms in spite of the barbiturate. As she was unable to take anything by mouth and was perspiring profusely, her fluid intake was increased to 4500 cc. of parenteral fluids daily by continuous drip. The temperature was still 104 degrees F. and the blood sulfadiazine concentration 12.8 mg.% with practically no urine output so the sulfadiazine was discontinued. 15,000 units of penicillin intramuscularly every 3 hours was started and continued the next day to a total of 175,000 units. It was obvious that the patient's condition was very critical largely because of the degree of muscle spasm and reaction to the slightest stimuli. Curare in the commercial form of Intocostrin was begun in doses varying from 20 to

40 mg. intravenously and intramuscularly. As a precaution against respiratory failure, either due to the tetanic convulsions or overdosage of curare, the patient was placed in a Drinker respirator. This proved to be a wise precaution because the patient ceased to breathe in the midst of a severe convulsion. In that a 29 minute elapse had occurred since curare was administered the respiratory failure was credited entirely to the tetanic convulsion. Artificial respiration was begun immediately and the patient responded. She was kept in the respirator almost constantly until the end, 24 hours later.

At the time curare was first given the patient was unable to open her mouth, did not respond to questions, was perspiring profusely and had marked trismus and opisthotonus. The slightest stimulus would induce violent muscle spasms. Curare was given as was deemed necessary (see chart) by the degree of muscle spasm with close attention being directed to the diaphragm. Within one minute after giving 40 mg. of curare intravenously there was general relaxation of all voluntary muscles. She was able to open her mouth to midposition. There was still no response to questions. Oxygen was begun by nasal catheter at this time. 1500 cc. 5% glucose in normal saline was also given. The patient was able to take liquids by mouth and talked freely thirty-five minutes after the third injection of curare. During the remainder of the night she took 1060 cc. of liquids by mouth.

In spite of more relaxation the general condition was not improving. The fourth hospital day the temperature rose steadily to 105 degrees F. At 6:50 p.m. our last dose of curare was given. At that time the patient had stridulous breathing and profuse hyperhidrosis, which latter was partly due to the intense heat inside the respirator. Ice bags were put inside the tank. At 9:00 p.m. she complained of pain over the entire abdomen and soon began to talk irrationally. In the middle of a sentence she quietly ceased to breathe at 9:20 p.m., approximately 3½ days after admission.

Curare was used in this case as almost a terminal measure. At the time curare was begun the patient was unable to open her mouth, did not respond to questions, had stridulous type of respiration, very marked opisthotonus and reacted vigorously with violent muscular spasms to the slightest stimulus. Barbiturates had not significantly reduced the muscle spasms either in duration or intensity. Within 35 minutes after the third dose of curare there was a dramatic change. The patient was alert, asked for water and drank 240 cc. There was a generalized relaxation of all muscles with the most marked changes in the pharyngeal, facial and hand muscles, with less relief in the arms, legs and abdomen. The respiration remained chiefly diaphragmatic.

As shown in the accompanying chart there was no regularity of dosage but rather usage according to the frequency and intensity of muscle spasms. At no time was there any objective change in the dia-

phragmatic breathing. The maximum relaxation occurred within the first minute with a gradual return to the original status in 20 to 30 minutes. This is in agreement with Burman's⁶ observations. However, in this case the time of relaxation was not constant and the response to any given dose could not be predicted. For this reason the dosage was kept small and frequent. No evidence of an accumulative effect was observed. With this dosage the danger of toxic effects seems small, which observation agrees with those of other observers. Once curare was begun there was no difficulty with bronchial spasm or hypersecretion although the use of atropine was discontinued. Cullen has reported the use of larger

individual dosage and a much greater total dosage with favorable results.

The terminal hyperpyrexia in this case cannot be explained on the existence of bronchopneumonia alone. While there was evidence of an early pneumonia, the physical signs did not indicate a critical respiratory status. Other observers also report this terminal hyperpyrexia with no definite explanation of its pathogenesis. Deitrich⁷ has pointed out the presence of a bulbar edema in children which may cause bulbar paralysis with terminal hyperpyrexia.

I wish to thank Dr. W. H. Kelley for permission to report this case and Dr. Robert P. Walton for his suggestions and criticisms.

CURARE TREATMENT

Time of Administration	Dosage Intocostin	Method of Administration
5-14-45		
12:55 p.m.	40 mg.	Intravenously
2:25 p.m.	30 mg.	"
2:35 p.m.	20 mg.	"
5:00 p.m.	20 mg.	"
6:00 p.m.	20 mg.	"
7:15 p.m.	20 mg.	"
8:15 p.m.	20 mg.	"
9:00 p.m.	20 mg.	"
9:20 p.m.	20 mg.	Intramuscularly
9:55 p.m.	40 mg.	"
10:35 p.m.	20 mg.	"
10:55 p.m.	20 mg.	Intravenously
5-15-45		
12:30 a.m.	20 mg.	Intravenously
12:40 a.m.	20 mg.	"
1:10 a.m.	20 mg.	Intramuscularly
1:45 a.m.	20 mg.	Intravenously
2:15 a.m.	20 mg.	"
2:50 a.m.	20 mg.	"
3:40 a.m.	20 mg.	"
3:55 a.m.	20 mg.	"
4:35 a.m.	20 mg.	"
5:00 a.m.	20 mg.	"
5:30 a.m.	20 mg.	"
6:05 a.m.	20 mg.	"
6:40 a.m.	20 mg.	"
7:10 a.m.	20 mg.	"
7:50 a.m.	20 mg.	"
8:30 a.m.	20 mg.	"
9:35 a.m.	20 mg.	"
10:25 a.m.	20 mg.	"
11:10 a.m.	20 mg.	"
11:40 a.m.	20 mg.	Intramuscularly
12:10 p.m.	20 mg.	"
12:40 p.m.	20 mg.	"
3:50 p.m.	40 mg.	"
6:50 p.m.	40 mg.	"
Total	810 mg.	

9 intramuscular injections to total 240 mg.

27 intravenous injections to total 570 mg.

SUMMARY AND CONCLUSIONS

1. A case of tetanus treated with curare in the form of intocostin is presented. The case was fatal.
 2. The cause of death clinically was due to bronchopneumonia, hyperpyrexia, bulbar paralysis or some other undisclosed complication of tetanus.
 3. Curare gave quick and efficient muscle relaxation in this case of tetanus.
 4. The action of curare was transient.
 5. There was no evidence of an accumulative effect from curare.
 6. There was no evidence of bronchial spasm or increased bronchial secretion as a result of the curare.
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EDITOR: Julian P. Price

Florence, S. C.

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Office of Publication: (In care of the Editor)

Florence, S. C.

Subscription Price

\$3.00 per Year

JANUARY, 1946

1946

Yesterday was dark.

The whine of bullets,

The rush of death-dealing planes,

The bursting of bombs,

The cries of tortured and dying men and women and children

Filled the air.

Nation rose against nation in fury and hate.

Destruction and death rode triumphant.

Suddenly the guns ceased firing.

All was quiet to the listening ear.

Peace had come.

But is it peace?

Have the hearts of men changed?

Are the peoples of the earth ready to live together

In the brotherhood of all?

O man, when wilt thou learn that peace can only come
Through the Spirit of Love,

When wilt thou learn that joy and laughter and
contentment can come,

To nations and to individuals alike,

Only through the living of the Golden Rule.

When wilt thou learn, O man, that the god of war
Will not be banished from the earth

Except as we,

The peoples of the earth,

Stand with bowed heads and reverent hearts,

Before the Prince of Peace.

IN CHICAGO

As the official representative and observer of the Association, it was the privilege of the Secretary to spend a week in Chicago the first of December attending conferences and the meeting of the House of Delegates of the American Medical Association. Making the trip with him were Dr. Hugh Smith, official delegate to the A.M.A., and Mr. M. L. Meadors, Director of Public Relations.

The first meeting which we attended was a day and a half Conference on Medical Service, sponsored by the A.M.A. Council on Medical Service and Public

Relations. Each state had been requested to have two representatives present.

As the conference progressed, the general theme seemed to be two-fold, (1) the medical profession, through its various organizations, must advance and put into effect an aggressive and progressive plan for bettering the medical care of our people, and (2) one of the main provisions in such a plan must be for providing voluntary pre-payment for medical services. Out of the conference came a resolution calling for the A.M.A. to sponsor the extension of voluntary prepaid medical service plans into all parts of the nation, with a national coordination of locally sponsored and administered plans. This resolution was subsequently adopted by the House of Delegates of the A.M.A. Medical Service plans, small though some of them are, are now operating in 26 states. The day is at hand when our South Carolina Association must consider such a plan for this state.

In passing, we would like to state that our Director of Public Relations, Mr. Jack Meadors, was asked to speak on the second morning of the conference. His remarks were timely and well received—and as a result, he has been invited to address a meeting of all Indiana county medical society officers in Indianapolis in January. We might also add that the leadership which our Association has taken in securing a Director of Public Relations was mentioned several times, and we believe that many other states will have a similar officer in the near future.

Following this conference we attended two half day meetings of state journal editors. Discussions here dealt largely with advertising and with the activities of the Cooperative Medical Advertising Bureau as it deals with the state journals. There were some fireworks, but the end result was that of amity and cooperation. The Cooperative Bureau has been particularly active during the past year and the advertising in our Journal has been at an all time high this past year. This will be borne out in the financial statement of the Association when it is published.

The third meeting attended was the Conference of Presidents and other officers of State Medical Associations. This organization has been operating among a group of midwestern and western states for two

years and was organized at this meeting into a national organization. Its purpose is to serve as a sounding board for discussion and dissemination of knowledge among the various state association officers. The program which was presented was one of the most interesting which it has been our privilege to hear.

The first speaker was Mr. Altmyer, Chairman of the Social Security Board, and his theme was the Plan for Medical Care recently advanced by President Truman. Beginning with the statement that the medical profession and government must work together, he stressed the point that government must have the help of the medical profession and that the medical profession must have the help of government. He then presented statistics to show that this nation was not the healthiest nation in the world as many claimed—we stand 7th in infant mortality, he noted. To show that government participation in medical care was nothing new in this country he showed where in 1944 the amount which government (federal, state, local) spent for medical care was one billion dollars—and this was exclusive of the medical care provided for those in the armed forces. Taking up the question of voluntary prepayment for hospital and medical care, he contended that voluntary insurance was inadequate to care for all the people (only 40 million have some form of protection at present against hospital bills and only from 5 to 6 million against medical service bills—and our population is 140,000,000). In closing he carefully stressed the difference between compulsory health insurance and state medicine. 30 countries have some sort of compulsory health insurance, he claimed, while only one country has state medicine (Russia).

Mr. Altmyer's address did little to change the opinions of those present except to give them a wholesome respect for this man who is a leader in the fight for Truman's Health Plan. His ideas may not agree with ours, but the facts which he presented and the logic which he used to strengthen his arguments show that he is no day-dreamer or passing social reformer. He is a strong and forceful individual and what he says will bear weight with many.

The next speaker was Dr. Philip Gillman, President of the California Medical Association. He presented the physician's view of the national scene from a medical standpoint and many felt that his was as fine a presentation as had been heard. (We will publish abstracts of this in the Journal at a later date.)

Much of the rest of the meeting was taken up with a discussion of a proposed National Health Congress. (We will also present this at a later date.)

All in all, the meeting was highly stimulating and showed conclusively that there are leaders in our profession who are fully capable of leading the medical profession in the days ahead, provided they are given the necessary support from their colleagues.

With these meetings aside, we attended the sessions of the House of Delegates of the A.M.A. It was with much pleasure that we noted a new spirit present in

this body, a spirit of aggressiveness, of desiring to move forward, of showing the people of the country that we were for something definite and not just opposed to whatever someone else proposed. There were still some who felt that we should continue in the way in which we had trod and venture upon nothing new, but such were in the minority.

Our delegate, Dr. Hugh Smith, made a splendid showing and no doubt will give a full report of the meeting at a later date. Although this was his first year, he was appointed to one of the important Reference Committees. For those who have never attended a meeting of the House of Delegates it should be stated that all reports and new business are immediately referred to a reference committee for consideration. The committee then brings it up before the House with recommendations—and the recommendations are adopted, with rare exception. The real debates, therefore, take place in the committee sessions rather than on the floor of the House. This does not mean that members of the House cannot discuss the recommendations of committees—they can, as much as they desire. One committee (Reference Committee on Legislation and Public Relations) had matters of such interest to all that the House of Delegates adjourned as such and immediately went into a meeting of this committee to consider matters under discussion.

This method of handling business might not appeal to some but we are convinced that it is the only way in which the House of Delegates could transact the mass of business which it is called upon to dispense with in a four day session.

Some of the matters presented for discussion and decision were: the need for an aggressive program, a national plan for prepayment of medical services, the care of veterans, the returning medical officer. To get a true picture of what was done, one should read the minutes of the meeting as they are now appearing in the Journal of the A.M.A.

One of the outstanding speeches of the meeting was made by Major General Hawley, Medical Director of the Veterans Administration. He convinced those present that the much desired change in the medical affairs of this organization are being made and that the administration of these affairs are in good hands.

The most important body in the A.M.A. is the Board of Trustees and the election of three members to this group of nine provoked a great deal of interest and activity. Three good men were elected: Dr. J. H. Fitzgibbon of Oregon, Dr. J. R. Miller of Connecticut, and Dr. Dwight Murray of California. It is our privilege to know two of these men personally and we feel that they will represent the profession well. The newly elected President-Elect is Dr. Harrison Shoulders of Nashville, formerly Speaker of the House of Delegates of the A.M.A.

This is the third session of the House of Delegates which it has been our privilege to attend. As one "on the outside looking in," it has been our observa-

tion that this year's gathering was far ahead of the other two in its desire to face the future and to give to the people the leadership which it needs in matters pertaining to medicine.

In conclusion, your Secretary would like to add

his word to those of your Delegate and your Director of Public Relations in suggesting that you try making trips to Chicago or other distant points by plane. It is no more expensive and it certainly saves time.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

CONFERENCE ON PREPAID MEDICAL INSURANCE

Acting in response to a Resolution adopted by the Public Relations Conference held in Chicago on October 19-20, the Council on Medical Service and Public Relations of the American Medical Association made arrangements for and held a conference on plans for prepayment for medical care at the AMA building on Nov. 30 and Dec. 1. All State Medical Associations were requested to send two delegates and the response was gratifying. The Secretary and the Director of Public Relations of the South Carolina Medical Association attended as delegates from this state.

The meeting was arranged so as to precede immediately the convention of the House of Delegates which opened on Dec. 3rd, so that the results of the conference might be reported to that body for prompt action. Dr. A. W. Adson of Rochester, Minn. was Chairman of the Conference, having presided over the round-table discussion on the same subject at the October meeting.

As an indication of the scope of inquiry and extent of the effort made, the complete program, as arranged by Dr. Adson and the agenda committee, is carried elsewhere on this page. The question under consideration was the feasibility of some form of national organization of a prepayment plan or plans for medical care, the form which such organization should take and the extent and means of possible co-ordination with the Blue Cross plans.

First on the program as arranged, following the addresses of welcome, on the opening day of the conference, was the presentation by Dr. Julian Price of Florence, of his proposal for a "National Organization of Prepayment Plans." Dr. Price emphasized, as an essential requirement for any such organization, that it provide for local management, control and operation of all the plans in the different states, with the national body taking the form of a federation of the various state plans, with supervisory powers as to standards and certain other matters. It provides for representation on the national governing body, of the Board of Trustees of the AMA, and of each State Medical Society, and would be financed in its opening phases by grants from the AMA.

This plan, which because of its importance and significance in the matters now under intense con-

sideration by the profession, is carried in full elsewhere in this department, would not attempt to confine medical prepayment plans to any special form, but would permit participation by any plan operated not for profit, for prepayment for medical care, regardless of whether it were on a service or indemnity basis. It would permit the fullest freedom of action and choice of method, as well as complete autonomy by each plan, yet all would be bound together by the common purpose, observing common standards as to maximum charges and minimum service or benefits, with complete reciprocity for subscribers.

The proposal, which bears evidence of thoughtful care in its preparation, provoked interesting discussion. It was the consensus of opinion before the conference closed, that the only satisfactory form of national organization for permanent adoption would be one which preserved complete self-control in its operation and the conduct of its financial affairs and policies, to the individual plans, as proposed by Dr. Price. While other forms were considered, it was recognized that any national corporation for insurance or as a holding company, would be acceptable only as an interim procedure, an emergency measure adopted for use at the moment, until state and other local plans could be organized in communities (like South Carolina) where they do not now exist, and until a basis for co-ordination, reciprocal action and common standards could be worked out among them.

Barring the possibility of passage of the "National Health Program" Act, rendering all such efforts *nil*, the plan outlined may well provide the basic structure for the type of national federation of plans which would constitute the practical solution of the problem. This and other proposals will be much discussed in future months and the members of this State Association will profit by its study and by thoughtful consideration of any ideas which it may suggest.

Dr. Price was appointed by Dr. Adson as one of a Committee of five to prepare Resolutions following the first days discussions, on the basis of the ideas suggested, and as expressing the sense of the conference, for presentation at the session on the following day, December 1st. This Resolution is likewise carried elsewhere on this page.

Another plan considered for the same ultimate objective was the organization of a national corporation which would operate in each state where there

is no existing medical prepayment plan. This national corporation would be charged with the responsibility not only of providing coverage but of fostering the development of other state and local organizations for the same purpose, and upon such organization the national corporation, as such, would withdraw and turn over the business acquired to the local plans. Some connection would be retained between the state organization and parent corporation. This idea was presented in detail in mimeographed form and supported on the floor of the conference principally by Dr. Frederick Elliot of New York City, who is now connected with one of the medical service plans there.

Still other ideas suggested and discussed were plans for the purchase by the AMA or by its members of an existing stock insurance company organized several years ago but not operated, with the view to placing it in operation on a non-profit basis as early as possible; a plan for the underwriting by a regular stock insurance company of the risks of the non-profit plans for prepayment for medical care, such as has recently been put into effect in Wisconsin; and a plan now being conducted with the assistance of the Continental Casualty Company for the handling by a stock insurance corporation of all of the administrative work and financing of medical prepayment plans for a definitely fixed percentage of the premiums paid. Finally, the possibility of a national organization for voluntary prepayment of medical and hospital care, along the same general line as that which is now operating successfully in the State of Michigan, was presented forcefully by Mr. Jay Ketchum, Executive Vice President of Michigan Medical Service, Inc.

Of all the foregoing, that which seemed to attract the most interest, as indicated by the resolution presented and adopted by the conference on the following day, was the suggestion advanced by Dr. Elliot of New York. It seemed to the majority of the conference that this idea offered the best possibility for a temporary arrangement which might be put into effect with least delay in order to hold the line while a more nearly ideal organization can be perfected.

On Saturday, Dec. 1, the resolution proposed by the committee appointed for that purpose was presented and, after spirited discussion, adopted almost without change by the conference. Also adopted at the same time was a summary of the considerations moving the conference toward the action taken.

The other part of the program originally scheduled for this session had to be changed, due to the fact that Mr. Theodore Wiprud of Washington could not be secured as the speaker. In the place of his address, Dr. Adson requested three of the lay representatives of the Medical Associations from the several states to discuss briefly their views and experience in connection with the matter of prepayment medical plans, public relations and related subjects. Included

on this part of the program were Mr. Nelson, of Ohio, Mr. Graham, of Okla., and your Director.

The conference was, in our opinion, very helpful and a progressive step toward coordination of the economic activities of the component state societies with the organized effort of the AMA.

REPORT OF THE SPECIAL COMMITTEE OF THE CONFERENCE ON VOLUNTARY PREPAYMENT MEDICAL CARE PLANS

Whereas, voluntary prepaid medical care programs, sponsored and operated by the medical profession in many parts of the country, are providing the means whereby millions of persons are able to obtain good medical care and hospital service on a budgeted basis; and

Whereas, this medical care has been rendered in a manner highly satisfactory to both patient and physician, and

Whereas, there are 47 voluntary plans in operation in 24 states, with almost every other state medical society in the process of developing plans, and

Whereas, in spite of this development some areas of the country have no such programs in operation at the present time; and

Whereas, these voluntary prepayment plans are based on the intrinsic American principles of personal initiative and personal responsibility, and

Whereas, the voluntary type of prepayment plan is to be preferred—in the interest of the people's health—to compulsory care under political control, and

Whereas, a large proportion of the people desire prepayment medical care programs, therefore be it

Resolved, that the House of Delegates take *immediate* steps to develop a national voluntary prepayment medical care plan:

For the purpose of covering areas not now served by plans;

To assist in the enrollment in local plans, and for the purpose of assisting in the enrollment plans for national enrollment groups, and

To serve until such time as all states have their own plans.

Resolved, that the American Medical Association's Council on Medical Service and Public Relations be instructed by the House of Delegates to take *immediate* steps to:

1. Coordinate the activities of all prepayment medical care plans now in operation.
2. Foster the development of such plans in those areas where there are none.
3. Educate physicians and the public as to the functions of voluntary prepayment plans and the need for supporting them.

and be it further

Resolved, that the officers and committees of every State Medical Society be urged by the House of Delegates to secure prompt action by their State



In the City of Bagdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the marketplace is the Honor and Integrity of him who makes it. Consider his name before you buy."

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Society in inaugurating new, or increasing the benefits of existing prepayment medical care programs in every state.

Respectfully submitted,

A. S. BRUNK
W. C. CHENEY
MARTIN I. OLSEN
JULIAN PRICE
CARL VOHS
J. R. MILLER, Chairman

SUMMARY OF SUGGESTIONS MADE AT CONFERENCE

The special committee of the conference reviewed the proceedings of yesterday and crystallized certain resolutions, which were based on the following suggestions made during discussion:

That the Council on Medical Service and Public Relations obtain from the House of Delegates authorization to develop a national voluntary Prepaid Medical Plan along the following guiding principles—

1. The Plan should be a (non-profit) stock corporation.
2. It should be chartered in one of the states and licensed to do business in all the others.
3. It should be under medical control.
4. Its original financing should be from medical sources, by contributions—loans without interest—from State Medical Societies and from local and state voluntary prepaid medical plans to be matched by grants from the American Medical Association.
5. The coverage at first should be surgical and obstetrical care on an indemnity basis.
6. It should be conveniently integrated with plans for Hospital care.
7. The purposes should be
 - a. To provide coverage in areas where no plans exist until such time as they can be developed.
 - b. To encourage the development of voluntary prepaid medical plans where they are lacking.
 - c. To supplement local and state plans in providing coverage for national enrollment groups.
 - d. To encourage local and state plans to provide a service type of contract for the lower income group, and for those whose costs of medical care are borne by taxation.
 - e. To encourage local and state plans to extend coverage as rapidly as is consistent with sound practice to include medical as well as surgical and obstetric care.

COMMITTEE ON MEDICAL COLLEGE COMPLETES WORK

The committee appointed by Council at the direction of the House of Delegates in October, for a study of proposals for expansion of the Medical College of South Carolina, has completed its work and as this is written, plans are being made for a report of its activities and recommendations to a called meeting of the House of Delegates on Jan. 3, 1946.

The committee, composed of 17 members made up of the president and the secretary of the state association, one member from each Judicial District of South Carolina, and the Director of Public Relations, held a meeting in Columbia shortly after its formation and outlined plans and methods of procedure.

The next step was a visit to Charleston for discussion with the Board of Trustees and members of the faculty, and an inspection of the present facilities of the Medical College. A thorough inspection was made, not only of the college itself, but of the facilities offered by Roper Hospital. There was a luncheon meeting with the Board of Trustees and members of the faculty, and in the afternoon representatives of the Charleston County Legislative Delegation and of the Charleston Chamber of Commerce were heard, as well as Dr. Robert Wilson, former dean of the college, Dr. Lynch, and others.

On November 20th, the committee met again in Columbia principally for the purpose of giving to the Richland County Legislative Delegation a requested hearing on the proposal to transfer the Medical College to the city of Columbia. The proposals of the Richland County group were presented in detail in written form and fully discussed by members of the delegation.

Following this, questionnaires were mailed by the secretary to all members of the committee, submitting to them certain questions which had developed in the course of the discussion at the different meetings and whereby the reaction of every member was sought and was, in fact, obtained, with only one exception. These questionnaires were summarized for presentation at the final meeting of the committee, which was held in Columbia on December 11th. After further discussion, the committee at this time adopted resolutions embodying its recommendations, which will be presented to the House of Delegates.

The interest and extent of cooperation by the committee members was remarkable, the attendance at most of the meetings being almost 100%. The doctors who composed the committee have shown a fine spirit of willingness to give freely of their time and thought to the consideration of matters of interest and improvement to the profession. The attitude of the members of this committee is inspiring and a splendid omen of what may be expected of the doctors in the future, in matters other than their private practices.



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NATIONAL HEALTH CONGRESS PROPOSED

On the afternoon of Dec. 2, we attended a meeting of the Association of Presidents and Secretaries of the State Medical Associations held at the Continental Hotel in Chicago. The meeting was under the sponsorship and the result of arrangements made by the Michigan State Medical Society which fostered the organization. A formal program had been arranged in advance and invitations issued to the presidents, secretaries and executive secretaries of the state associations.

Several timely and interesting papers were presented, emphasizing the necessity of active participation by the medical profession in the economic field at this time. One of these by Dr. P. K. Gilman, president of the California Medical Association, was outstanding in the manner in which it was presented and in the graphic description of the tasks ahead based upon the speaker's experience with the C.I.O. and other organizations, in the course of the efforts to enact legislation for compulsory medical care in California during the last session of the legislature in that state.

The most challenging proposal presented at the meeting was that for a National Health Congress, a plan sponsored by Dr. A. S. Brunk, President of the Michigan State Medical Society, John R. Mannix, Director, Plan for Hospital Care, Chicago, and Mr. John F. Hunt, Vice President, Foote, Cone and Belding, Chicago. The proposal was presented by Mr. Hunt, whose firm made the survey and analysis with reference to the public attitude and demand for change in connection with medical practice, in the states of California and Michigan.

The idea of the National Health Congress is to bring together in a voluntary organization all those agencies and instrumentalities in the country, including the government itself, which are responsible for or vitally concerned with the furnishing of medical service, hospital care and related benefits. It would provide for representation of industry, labor, the professions and business. It is designed to reach into every part of the nation and if successful, would therefore provide the means for national administration and supervision of the services with which it is concerned, and match effectively the scope of the programs proposed for administration and control by the government.

Mr. Hunt pointed out the absolute necessity for some such voluntary action if the government's challenge is to be met. He called attention to the unusually large number of bills proposed in state legislatures during the past year, to which references have been made in this column in previous issues. It was his opinion that the complete health protection for every individual which is imminently desirable and which is being demanded by certain organized

groups is not impossible of attainment "provided the methods employed to achieve it are right." The idea of a National Health Congress embodies the most comprehensive and concrete outline of those methods which we have seen. The following are some of the specific proposals embraced in the plan:

Formation and Objectives: The National Health Congress would be formed by merging or pooling all voluntary health abilities to accomplish these objectives:

1. Extending a standard health protection to all people through voluntary means.
2. Extending the physical facilities for health to the point where complete protection becomes possible for all people of whatever status and wherever located.
3. The national coordination of all health agencies and their activities to this end.
4. Effecting a plan of voluntary prepayment of health protection at an equal or lower cost than that proposed by the Murray-Wagner-Dingell Bill.
5. Education of the public on all matters pertaining to health, tending both to improve national health standards generally and to increase public interest in taking advantage of the facilities for health improvement.
6. The continuation of incentives for those in all phases of health care.

Type of Organization: The National Health Congress is envisioned as a national organization patterned after our national legislative congress. As proposed, it would be not merely an organization providing a public forum for the discussion of health practices and objectives, but a legislative body created by the voluntary health forces and endowed with the power to act for them.

Membership: As proposed, the National Health Congress membership would be made up of a representative or representatives of (1) each state hospital association, (2) each state medical association, (3) each state dental association, (4) each state nursing association, (5) each state pharmaceutical association, (6) the industry of each state, (7) the labor of each state, (8) the agriculture of each state and (9) a representative of the United States Senate, the House of Representatives and the United States Public Health Service.

Scope of the Congress: The scope of the National Health Congress would cover all measures affecting health care on the national plane, specifically those aimed at:

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Accelerates burn healing, shortens time by as much as 50%*. Minimizes scar formation and speeds regeneration of tissue.

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1. Extending standard health coverage to all people of any economic status wherever located.
2. Extending facilities and research projects necessary to further the improvement of health standards of the nation.
3. Evolving a sensible prepayment method, covering all items of health care on an economical cost basis for the individual or family unit.
4. Studying and recommending to the federal and all state governments their proper and most productive participation in the health activities of the nation and states, particularly the endowment of greater research projects, and the extension of benefits to the indigent and public wards.
5. Empowering a national health administration under its control to carry out its directives.

(Conference on)

PREPAID MEDICAL INSURANCE

on a

NATIONAL VOLUNTARY BASIS

AMERICAN MEDICAL ASSOCIATION

HEADQUARTERS

November 30, 1945

10:00 - 12:00 a.m.

Voluntary Prepayment Medical Care vs. Compulsory Medical Insurance—Dr. H. L. Kretchmer, president of A. M. A.

Position of the American Medical Association re. Voluntary Prepayment Medical Plans—Dr. Olin West, secretary and general manager of the A. M. A.

National Organization of Prepayment Medical Service Plans—Dr. Julian Price, Florence, South Carolina.

Medical Service vs. Indemnity Plans for Prepayment Medical Care on a National Basis—Dr. Frederick Elliott, New York City; Dr. Norman D. Scott, Newark, New Jersey; Dr. Charles H. Phifer, Chicago, Illinois; Dr. Frank L. Feierabend, Kansas City, Kansas.

The Advisability of Coordination of Blue Cross and Medical Service Plans on a National Basis—John R. Mannix, Chicago, Illinois; Dr. C. Rufus Rorem, Chicago, Illinois.

Luncheon—Kungsholm Swedish Restaurant.

2:00 - 4:00 p.m.

National Medical Plan—Dr. Frank L. Feierabend, Kansas City, Kansas; Dr. Frederick Elliot, New York City.

Industrial Physician's Plan—Dr. Carl M. Peterson, secretary for Council on Industrial Health.

Wisconsin Plan—C. H. Crownhart.

Continental Casualty Company—J. A. Hampton, Chicago, Illinois.

American Health Insurance Corporation Plan—Don C. Hawkins, St. Paul, Minnesota.

A National Plan of voluntary Prepayment Medical and Hospital Care—Jay Ketchum, executive vice President of Michigan Medical Service Inc., Detroit, Michigan.

December 1, 1945

10:00 - 12:00 a.m.

The role of Organized Medicine in the Promotion of Prepayment Medical Plans—Theodore Wiprud, Washington, D. C.

General Discussion.

Presentation of resolutions for discussion and adoption with recommendation to the House of Delegates of the A. M. A.

PROPOSED PLAN FOR A NATIONAL ASSOCIATION OF MEDICAL SERVICE PLANS

Julian P. Price, M.D., Secy. S. C. Med. Assoc.

NAME

The name of this organization shall be the National Association of Medical Service plans.

PURPOSE

The purpose of this Association shall be to

- (1) enhance and coordinate the activities of medical service plans in operation,
- (2) foster the development of medical service plans in those sections of the country where there are none,
- (3) educate physicians and the public as to the function of medical service plans and the need for supporting and making use of them.

PARTICIPATING MEMBERS

Participating members shall consist of those medical service plans which have received a certificate of membership from the Association.

COMPOSITION OF THE ASSOCIATION*

This Association shall consist of a Council and a Board of Directors.

THE COUNCIL

The Council shall consist of

- (1) one duly elected representative from each state medical association,
- (2) one duly elected representative from each participating member,
- (3) five representatives elected by the Board of Trustees of the American Medical Association.
- (4) the Secretary of the American Medical Association,
- (5) the Board of Directors of this Association.

DUTIES OF THE COUNCIL

It shall be the duty of the Council to

- (1) elect the Board of Directors,
- (2) make recommendations to the Board of Directors,
- (3) hold an annual meeting.

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154.

Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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THE BOARD OF DIRECTORS

The board of Directors shall be composed of twelve members. All members must be Fellows of the American Medical Association or Executive Officers of a State Medical Association or of the American Medical Association. No two members of the Board of Directors shall be residents of the same state.

The term of office for the members shall be three years, and no members shall serve for more than two consecutive full terms.

DUTIES OF THE BOARD OF DIRECTORS

The Board of Directors shall be the legislative body of the Association.

- It shall be the duty of the Board of Directors to
- (1) establish standards for participating membership,
 - (2) receive applications for participating membership and to issue certificates for participating membership to those medical service plans whose applications are approved,
 - (3) serve as a clearing house of information on matters concerning medical service plans,
 - (4) serve as a liaison group between medical service plans and hospital service plans,
 - (5) institute a program of education which shall inform physicians and the public as to the function

of, the need for, and the desirability of participating in medical service plans,

- (6) furnish information and aid to any participating member or to any medical association desirous of establishing a medical service plan,
- (7) consult and cooperate with such other organizations and groups of individuals as are endeavoring to improve the medical welfare of our citizens through voluntary pre-payment for medical services,
- (8) employ such personnel and rent such office space as may be necessary to carry on its work most effectively,
- (9) present an annual report to the Council.

FINANCES

For the first two years of operation, the expenses of the Association shall be met through grants from the American Medical Association. At the end of this two year period, a permanent plan for financial support shall be adopted which shall be mutually satisfactory to the Board of Directors of the Association and the Board of Trustees of the American Medical Association.

EMBLEM

A distinctive emblem for the Association shall be adopted by the Council and the right to use this emblem shall be given to all participating members.

DEATHS

Henry L. Scarborough

Dr. Henry L. Scarborough of Conway, South Carolina, died suddenly of coronary thrombosis at his home on December 18. Doctor Scarborough was a graduate of the University of South Carolina and of the Medical College in Charleston in the class of 1912. Besides being a member of the staff of the Conway Hospital, Doctor Scarborough carried on an extensive general practice throughout the length and breadth of Horry County. He had finished a very full day of work at the time his fatal attack occurred.

William S. Lynch

Doctor William S. Lynch died suddenly at his office in Lake City on the morning of December 21. Doctor Lynch was a graduate of the Medical College of the State of South Carolina, Class of 1899. He was a veteran of the first World War, having served as a major in the medical corps. For the past twenty-five years he had practiced in Lake City. Surviving are one son and one daughter.

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PUBLIC HEALTH NEWS

MATERNAL DEATH RATE IN SOUTH CAROLINA REDUCED MORE THAN HALF SINCE 1936

According to figures recently released by the Bureau of Vital Statistics, South Carolina's maternity rate has been reduced approximately 52 per cent since the Division of Maternal and Child Health was organized in 1936.

The steady decline of the maternal death rate during the past 8 years and the total number of deaths during each of those years are shown in the table below.

Maternal Deaths	Number	Rate per 1,000 live births
1936-37	295	7.7
1937-38	302	7.5
1938-39	264	6.6
1939-40	263	6.2
1940-41	263	5.7
1941-42	266	5.5
1942-43	256	5.2
1943-44	201	4.1
1944-45	190	3.7

Local and state medical and health services played a large part in saving these lives.

BIRTHS INCREASE, DEATHS DECREASE IN SOUTH CAROLINA DURING 1945

According to the 1945 annual report of the Bureau of Vital Statistics, there were 2,316 more births and 1,211 fewer deaths in South Carolina during the past fiscal year than in 1944. The total number of births recorded for 1945 was 51,682 as compared to 49,366 for 1944. Deaths recorded during 1945 numbered 17,166 as against 18,377 for 1944.

Of the births registered for 1945, 27,895 were white, and 23,787 were colored. White deaths totalled 8,631, colored deaths 8,535.

The greatest number of deaths in the State last year was caused by diseases of the heart, which claimed 3,465 lives. Next in line were kidney diseases, apoplexy, embolism, thrombosis of the brain, violent and accidental deaths, diseases peculiar to the first year of life, cancer, pneumonia, digestive system, tuberculosis, and syphilis.

Of the 693 deaths from tuberculosis, 30 per cent were white and 70 per cent colored.

Malaria claimed 51 lives, cancer 1,203, diphtheria 30, and pellagra 48.

Infant deaths numbered 2,694, with premature births accounting for 740. It is interesting to note that a statistical study of infant deaths in 1944 re-

vealed that of the 2,898 deaths recorded that year, 696, or 24 per cent, died *without medical attention*.

Despite the rapid increase in the State's population during the war years, a comparison of the number of deaths from certain causes in 1945 with those in 1937 gives an encouraging picture of the progress made in public health during the past eight years.

STATE BOARD OF HEALTH KEEPING WATCHFUL EYE ON PUBLIC EATING PLACES

If there is any place in the commonwealth where cleansing of eating implements is likely to be hurried and indifferent, it would seem to be at lunch stands operated at State and county fairs.

The stands are usually temporary affairs, occupied for a week; the men and women who operate them are in a rush to serve as many customers as possible; the customers too are in a hurry to be served and want to get back to the exhibits or to the midway. They are likely not to be too particular or exacting. The help employed is often not any too well trained.

Yet E. T. Ammons, principal sanitarian at the State Board of Health, reports that acceptable standards of cleanliness were maintained at the dozen or more eating places in the State fair held this fall in Columbia.

The day the State fair opened, when the lunch stand operators were getting started, he and others of the health department went out to the grounds and held a sort of impromptu training school and insisted that some chemical sterilizing agent be used in washing dishes, spoons, cups, drinking glasses and forks. He wanted no food poisoning at the State fair, and the stand operators seemed eager to accept every suggestion for cleanliness.

After the fair had been under way a few days, it was visited again and swabs taken from dishes, glasses, forks and so forth and tests were made for bacteria. Almost every test showed that standards acceptable to health authorities were being maintained. Mr. Ammons thought the showing remarkable because of the very nature of the operation of a State fair lunch room.

Last year, Mr. Ammons says, cultures were made on 3,855 utensils in 220 eating places, most of them restaurants and cafeterias.

Of these cultures, 2784, or about three-fourths of all taken, proved satisfactory. The utensils from which cultures came were generally sterile and only in a few were the bacteria too numerous to count.

"Operators are trying to keep drinking glasses,

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cups, spoons, forks and so forth clean. It is the utensil that goes into the mouth of the customer that we particularly watch," he said, "since it would be the one that is harmful should it carry disease germs."

In the coming year, Mr. Ammons will continue to give attention to classes in food handling. Perhaps not so many people are eating in restaurants and cafeterias today as was the case when the war effort was at its peak, but even yet there are thousands who take one or more meals away from home every day, and who assume that the forks and glasses they use are sterile.—R. E. Grier, *The State*.

COUNTIES AND CITIES URGED TO FILE APPLICATIONS FOR HEALTH PROJECTS

Originally, the Federal Works Agency set aside seventeen and one-half million dollars for an over-all program on postwar projects. This seventeen and one-half million dollars was earmarked for Advance Planning for Non-Federal Public Works. The State of South Carolina's share of this money amounted to \$216,000.00, and it was obligated within thirty days after the plans were started. Since that time, additional money was granted to the State of South Carolina, and on December 4, 1945, a total over-all grant to this State amounted to \$1,751,498.00.

Again there will be a slight delay of advancing money on plans for the various projects throughout the State, but we have assurance that additional money will be allocated to this State, so that plans and procedure on preparation of projects will not be curtailed.

We are urging all counties and cities who are interested in securing water systems and extensions, sewerage systems and extensions, County Health Centers and Hospitals, to get their applications filled at the earliest possible time. So far, in the State of South Carolina, on an over-all basis, we have filed and approved all types of projects in the amount of \$61,690,300.00.

We should at least have a hundred million dollars as a back-log, so that when money is made available for construction we can begin our building program without delay. All tax supported institutions are eligible under this program.—H. M. McElveen.

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apparently must be maintained at a level above normal in order to assure proper wound healing* and at least average resistance against infection.** The feeding of meat, therefore, in adequate amounts, as soon as it can be instituted, appears doubly advantageous: the protein content of meat is high and of highest biologic value; the human digestive tract appears well adapted for handling meat protein.**

*“ . . . in a variety of medical and surgical conditions there may occur a considerable depletion of body protein owing to a combination of factors, of which the two most important are a generally diminished protein intake and an enhanced protein catabolism. This situation inhibits wound healing, renders the liver more liable to toxic damage, impedes the regeneration of hemoglobin, prevents the resumption of normal gastrointestinal activity and delays the full return of muscular strength. It is obvious that to meet the situation an adequate supply of proteins and calories must be made available to the body. . . . This implies at least 150 Gm. of protein and 3500 calories, with as much as 500 Gm. of protein daily when trauma has been severe, as in serious burns.” (HOFF, H. E.: Physiology, New England J. of Med. 231:492 [Oct. 5] 1944.)

**“Cannon . . . cites the evidence which indicates that diminished protein intake lowers resistance to infectious disease, and corroborates it by his own experiments . . . it seems probable that the small intestine is better adapted for handling protein (especially meat protein) than for other types of food. . . . it is especially well supplied with enzymes which attack protein, and the digestion of meat has been shown to be more complete than that of foods of vegetable origins.” (CRANDALL, L. A., Jr.: The Clinical Significance of the Plasma Proteins, Memphis M.J. XIX:147 [Oct.] 1944.)

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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NEWS ITEMS

Dr. Rowland F. Zeigler has been appointed to a fellowship in obstetrics and gynecology at the Alton Ochsner Medical Foundation in New Orleans for a year beginning January 1. While there he will be personal assistant to Dr. Conrad Collins who is Professor of Gynecology at the Tulane University Medical School and a staff member of the Ochsner Clinic. Dr. Zeigler has been practicing in Seneca for the past six years.

Colonel O. B. Mayer has received his discharge from the Army and reopened his offices in Columbia.

Dr. John K. Webb, who has been associated with Dr. W. T. Brockman in Greenville since his discharge from the Army in September, has been awarded a fellowship in surgery at the Lahey Clinic at Boston. Dr. Webb entered the clinic January 1 for further study in surgery.

Dr. J. Warren White of Greenville has received the honor of being elected to membership in the Southern Surgical Association.

Dr. George Smith, formerly of Florence, has been awarded a fellowship in dermatology and syphilology with Dr. Donald Pillsbury, Department of Dermatology at the University of Pennsylvania Medical School.

Cards have been received recently as follows: James E. Boone, M.D. and William T. Barron, M.D. announce their association in the practice of urology and genito-surgery, 1517 Hampton Street, Columbia, S. C.

The Third District Medical Meeting was held at Greenwood on November 27. The guest speaker was Dr. Ristine, neurologist of the Medical College of University of Georgia, who presented a very

interesting paper on PAIN. Dr. W. T. Brockman, President of the S. C. Medical Association, was present and made a short talk. Officers elected for 1946 were: Dr. C. J. Scurry, President; Dr. W. G. Bishop, Vice President; Dr. H. B. Morgan, Secretary treasurer.

At the November 27th meeting of the Medical Society of South Carolina Dr. Wm. H. Prioleau read a paper on MUSCLE-FLAP CLOSURE OF LUNG ABSCESS CAVITY. This was illustrated by lantern slides and was discussed by Drs. A. E. Baker, Kredel, Smithy, O'Driscoll and Buist.

The Southeastern Surgical Congress will hold its next Assembly at Memphis, March 11, 12, 13, 1946 at the Peabody Hotel.

The following is a partial list of those who will take part on the program:

Dr. Conrad G. Collins, New Orleans
 Dr. Merrill N. Foote, Brooklyn
 Dr. Clarence E. Gardner, Durham
 Dr. James E. Hemphill, Charlotte
 Dr. Robert Hingson, Jr., Staten Island
 Dr. Arnold Jackson, Madison, Wis.
 Dr. Roy R. Kracke, Birmingham
 Dr. Karl A. Meyer, Chicago
 Dr. J. O. Morgan, Gadsden, Ala.
 Dr. Curtice Rosser, Dallas
 Dr. Harold E. Simon, Birmingham
 Dr. G. L. Simpson, Greenville, Ky.
 Dr. Horace G. Smithy, Charleston, S. C.

The Medical Profession is invited to attend the Assembly. For information write Dr. B. T. Beasley, Secretary-Manager, Atlanta 3, Ga.

Happy New Year

With sincere appreciation of the cordial relationship we have enjoyed through the past year, we pause to say thanks, and wish you a new year filled with happiness and prosperity.

We look forward to serving you in 1946 in the same friendly way.

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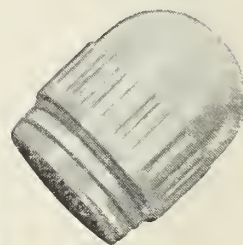
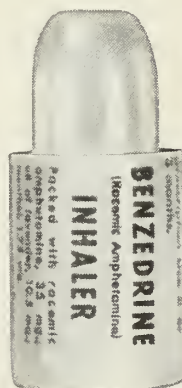


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The Journal of the South Carolina Medical Association

FEBRUARY, 1946

VOL. XLII, NO. 2

CONTENTS

Article	Author	Page
The Use of Histamine Compound in the Treatment of Infantile Eczema	George D. Johnson, M.D.	29
National Health Program Message from the President of the United States		31
Special Meeting of the House of Delegates of the South Carolina Medical Association		34
Editorials — The Ten Point Program — Woman's Auxiliary — News Items Public Health News		

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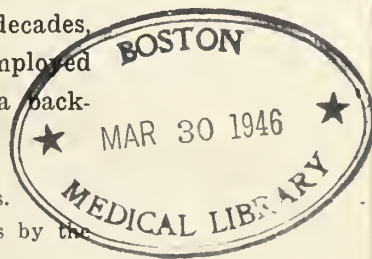
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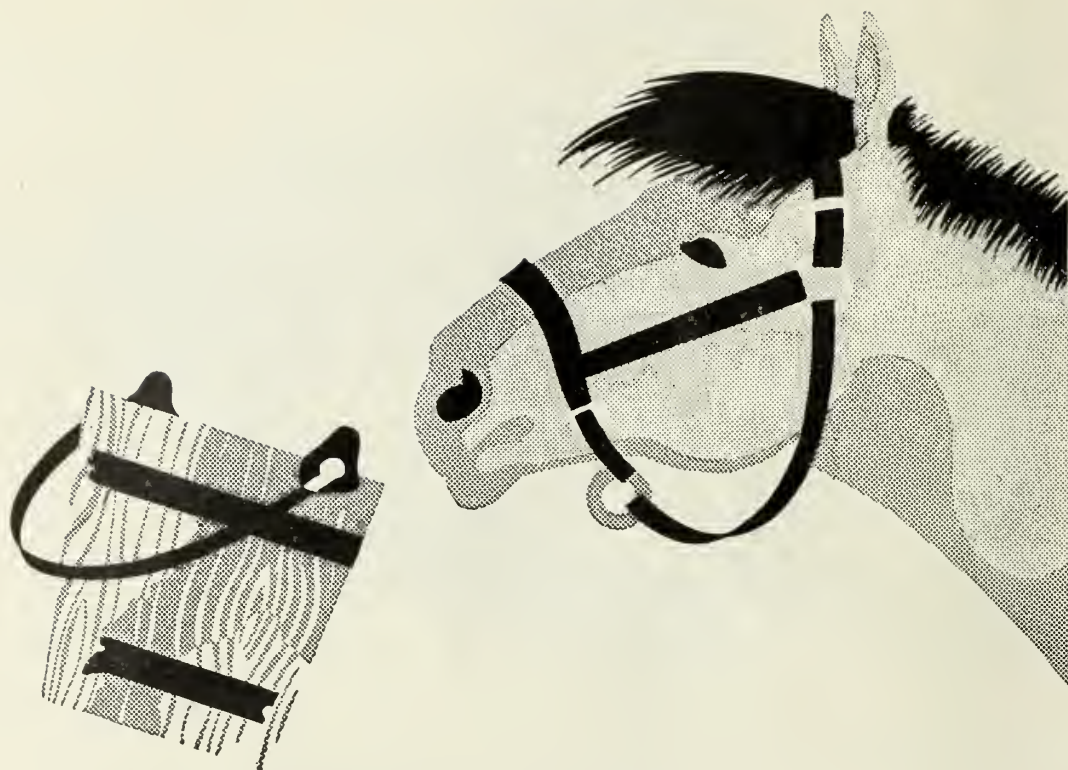
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Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879.
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918.

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

February, 1946

NUMBER 2

The Use of Histamine Compound in the Treatment of Infantile Eczema

GEORGE D. JOHNSON, M.D., SPARTANBURG, S. C.

The treatment of eczema and similar allergic skin disorders in childhood is unsatisfactory. As a rule, these cases develop more slowly than the normal child. Some cases lead a miserable existence of scratching, sleepless nights for children and for parents. The time honored treatments are well known and carefully followed. Elimination diets where eggs, tomato, fruit juice, milk, wheat are left out of the diet are frequently partially or completely effective in mild cases. The use of some type of tar ointment in uninfected allergic rashes is an old and effective aid in treatment. Desensitization by mouth or by injection of dilute solutions of the offending protein is sometimes accomplished. The rash in nearly all these children disappears when the child reaches two, three or four years.

Parents are not content with a relatively mild rash that annoys mother and child even though the child develops properly. Patient and mother want to sleep at night. The mother is not content with the assurance that the child will outgrow his malady. Another mother even though the child sleeps well at night does not like the cosmetic effect of a rash on both cheeks, in both elbows and behind both knees of an otherwise beautiful child. This new method has been used only on those cases which have not responded to the usual treatments outlined above. It has been used in intractable cases because of their severity or because of their cosmetic effects.

The material used is a combination of histamine and a protein joined by an azo radical. The rationale for its use is based on physiological facts and theoretically would appear to be the ideal method of treatment. Where there is evidence of allergy, such as urticaria, eczema, neurocirculatory edema there is said to be a liberation of histamine. If the patient could be desensitized against histamine, or if histamine would not be liberated in the tissues in the

presence of the offending protein, whether it is known or not, then no symptoms would occur. That is, if histamine is as intimately associated with allergic disorders as some authorities think.¹ Histamine itself has no antigenic properties. If injected into an animal in gradually increasing doses, no antibodies in that individual will be developed. Several investigators² felt that if histamine could be attached to a protein, and this combination injected, then antibodies against the histamine would be developed. This apparently is the result in the product under discussion.

Every case in this small series had been treated by one or more doctors using the usual treatments for difficult eczemas. Each case was given an intradermal skin test of .1 cc hapamine diluted in 10 cc of sterile distilled water. If this test were negative after 30 minutes .2 cc of the above dilution was used. At the next visit undiluted hapamine .1 cc was given subcutaneously. Injections were given three times a week as a rule, sometimes as often as every four hours. The dosage was increased by .1 cc of undiluted hapamine at each subsequent dose unless there was a local reaction. Only a few occurred in this series and none was severe. The dosage at which improvement was noticed varied. Sometimes .5 cc was the correct amount, commonly 1 cc and as much as 2 cc has been given in severe cases. The manufacturer recommends much smaller dosage.³ Once a maintenance dosage is reached the interval can be reduced to once a week, once every two or three weeks, and sometimes can be left off entirely. If discontinued entirely some cases will have recurrences. The following are some of the more representative cases:

(1) C. F., age 4 months. Arms and legs bandaged, underweight, child on milk substitutes, maintenance dose 1 cc. Free from rash entirely for about 3 months. For past few weeks rash has returned in mild form. Amazing change in growth, appetite,

¹Hapamine is prepared by Parke, Davis, & Co.

and sleep of child.

(2) W. C. age 8 months. Father has asthma and eczema. Underweight, fairly well covered with eczema, but not bleeding or secondarily infected. Maintenance dose 1 cc. Free from rash entirely for about 2 months. Slight rash now. Growth and appetite greatly improved.

(3) E. D. (colored) age 7 months. Weeping eczema of cheeks, elbows and behind knees. Improved after .8 cc was reached. Maintenance dose 1 cc. Rash entirely gone now.

(4) K. W. (colored) age 8 months. This was the most severe case of the series. She had a generalized eruption all over body and in scalp. Showed much improvement after $1\frac{1}{2}$ cc dose was reached. Was better for 6 weeks, then began to break out again. Two cc was given three times a week for two weeks with no improvement and it was discontinued.

(5) D. W. age 7 months. Generalized rash over trunk, buttocks and thighs. Cleared entirely after maintenance dose of .5 cc was reached.

(6) E. M. 15 months. Showed improvement after .3 cc of hapamine was reached. Cleared entirely after .4 cc was reached. Parents discontinued treatments. After 3 months rash returned and it was cleared up again.

(7) D. G. age 20 months. Generalized eruption. Mother and child could not rest at night. Some improvement after 1 cc was reached. Dose increased to $1\frac{1}{2}$ cc for about 1 month, child almost well, dose decreased to 1 cc every 2 weeks. Child and mother sleep now, both have gained weight. Almost free from rash for 4 months, but still gets a dose every 2 or 3 weeks. (Last week the mother called from a nearby town where she has moved and asked that she be sent some hapamine—the rash was a little worse—no maintenance dose.)

(8) F. B., age 20 months. Some improvement after .5 cc was reached. Maintenance dose of 1 cc. Rash well.

(9) J. C., age 3 years. Chronic but mild eczema on cheeks, elbows and behind knees. Cleared entirely when maintenance dose of 1 cc was reached.

(10) S. G., age 23 years, a Filipino mother. Since living in South Carolina two years had developed on arms and legs circumscribed lesions of oozing and itching which had not responded to any other treatment, cleared entirely on a maintenance dose of 1 cc.

(11) N. H., age $2\frac{1}{2}$. Chronic eczema on face, elbows and behind knees. Cleared on 1 cc maintenance dose. When mother stopped bringing her in the rash reappeared after 6 weeks.

There were at least six cases of what appeared to be a simple heat rash with secondary infection of a mild nature. These cases showed no response to the usual simple methods of treatment, but cleared promptly and completely after a maintenance dose of .5 cc was reached.

Comment: Just evaluation of treatment of eczema is difficult because of the normal remissions and relapses of the rash. The mothers have been much more enthusiastic about the results than I have dared be.

Certain cases require that a maintenance dose be continued while in others apparently it can be discontinued. No method has been determined to indicate which cases need to be treated continuously, but it would seem that the more severe cases would require more treatment. This method will not cure every case as witness case (4), but it is an effective aid in this type disorder. The point which the parents stress more than any other is not necessarily the disappearance of the rash, but rather the change that comes over the baby. When effective, he rests better, eats better and consequently gains weight rapidly. His general condition is greatly improved. This was especially true of cases (1), (7), and the six cases of mild heat rash.

Summary:

(1) A new aid in the treatment of allergic skin disorders is outlined. Its rationale is described.

(2) While not effective in every case, in this small series of about eighteen, it has been found so helpful that it should be tried more extensively. Only one case was not improved.

(3) A brief summary of typical cases is presented.

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National Health Program Message from the President of the United States

(On November 19, 1945, President Truman presented a message to the Congress dealing with a National Health Program. This message will play an important part in the Congressional discussions during the coming weeks and months. We feel that every physician should be acquainted with the proposals of the President. Space forbids publishing the message in full but we herewith present those parts of his message which are of primary concern to physicians. Copies of his entire message may be secured from members of Congress.—Editor)

There are five basic problems which we must attack vigorously if we would reach the health objectives of our economic bill of rights.

1. The first has to do with the number and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel—doctors, dentists, public health and hospital administrators, nurses, and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were 31 counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason—closely allied with the first—is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

The demobilization of 60,000 doctors and of the tens of thousands of other professional personnel in the armed forces is now proceeding on a large scale. Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with greater financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics, and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 per cent of the total in the country, with some 15,000,000 people, have either no local hospital or none that meets even the minimum standards of national professional associations.

The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public health services and maternal and child care.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

In the aggregate, all health services—from public health agencies, physicians, hospitals, dentists, nurses, and laboratories—absorb only about 4 per cent of the national income. We can afford to spend more for health.

But 4 per cent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs and not average costs. They may be hit by sickness that calls for many times the average cost—in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons,

however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us knows doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them. I am sure that there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts, each of which contributes to all the others.

First. Construction of Hospitals and Related Facilities

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers, and other medical, health, and rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services—for both prevention and cure—can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed but also to enlarge or modernize those we now have.

Second. Expansion of Public Health, Maternal and Child-Health Services

Our programs for public health and related services should be enlarged and strengthened.

Third. Medical Education and Research

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields and to encourage and support medical research.

Fourth. Prepayment of Medical Costs

Everyone should have ready access to all necessary medical, hospital, and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk and to benefit the insured who actually suffers the loss. If, instead of the costs of sickness being paid only by those who get sick, all the people, sick and well, were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the

principle upon which all forms of insurance are based.

During the past 15 years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3 or 4 per cent of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist, and laboratory services, as needed, would also become available to all and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing, and laboratory services. It should also cover dental care—as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally in order to establish the broadest and most stable basis for spreading the costs of illness and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on State-by-State action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross State boundary lines.

Medical services are personal. Therefore, the Nation-wide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should be adjusted locally. All such rates for doctors should be adequate and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the

health-insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health-insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county, and State general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals, or others for health services but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine."

I repeat—what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now—on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, Government employees, and employees of nonprofit institutions and

their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public-assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the States in paying for medical services provided by doctors, hospitals, and other agencies to needy persons.

Premiums for present social-insurance benefits are calculated on the first \$3,000 earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount such as \$3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4 per cent of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists, and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a Nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals.

We are a rich Nation and can afford many things. But ill health which can be prevented or cured is one thing we cannot afford.

Fifth. Protection Against Loss of Wages from Sickness and Disability

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will, of course, come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness.

HARRY S. TRUMAN.

THE WHITE HOUSE, November 19, 1945.

Special Meeting of the House of Delegates of the South Carolina Medical Association

JAN. 3, 1946, COLUMBIA, S. C.

Dr. W. T. Brockman: The meeting will please come to order. We will have the roll call by the Secretary.

(Roll called by the Secretary and corrections made as to new delegates, etc.)

Dr. Brockman: As you know, it is customary at these meetings for only delegates to speak. In view of the purpose of this called meeting and the importance of the matters to be taken up, it might be well to throw this meeting open to all members of the association, if you feel like it.

Dr. J. D. Guess: I move that the privilege of the floor be extended to all members of the Association. (Motion seconded and carried.)

Dr. Brockman: The Chair will recognize our delegate to the American Medical Association, Dr. Hugh Smith.

Dr. Smith: Mr. President, and gentlemen,

In attending my first meeting of the House of Delegates of the American Medical Association my path was made easier through the courtesies of Dr. William Weston of Columbia and Dr. Julian Price of Florence, both familiar with the House and many of its older members. They were indeed a real help and I am grateful to them. Perhaps, like a freshman anywhere, a new Delegate must sit, look and listen. The organization of the House of Delegates is rather large and business like. There is much to be done in a few days and my impression of my first session is that much is done, smoothly, industriously and earnestly.

The addresses of President Roger I. Lee of Boston on "What Is Adequate Medical Care" was splendid. He is a good speaker, an outstanding medical man and a great teacher. He will serve the American Medical Association well. Dr. Harrison Shoulders of Tennessee became President Elect. He has served for several years as Speaker of the House. He is a Southerner, familiar with the workings of the American Medical Association and an able physician.

The Reference Committee on Legislation and Public Relations, chairman, Dr. Edwin S. Hamilton of Illinois, reported on the much discussed and often cussed Wagner-Murray-Dingell Bill. The committee expressed the whole hearted and apparently unanimous opposition of all medical men in private practice to the inherent dangers in such a law. The bill offered by Senator Pepper furthering the activities of the Maternal and Infant Care program was also disapproved. This latter plan reaches the state of sublime ridiculousness whereby infant care extends to age twenty-one, and at the same time our selective service plan now says a boy of eighteen is a man

and mature enough to serve in the Armed Forces. To my mind both are fallacious.

A new section devoted to the General Practice of Medicine was organized and the by-laws so changed to make it a regular section of the clinical meeting annually. With a few years experience this should become one of the most popular and useful clinical sections.

There was sincere praise for the work of American physicians in the Military Services this last war. There were 60,000 or more in the Armed Services. Their record of accomplishment is a splendid one indeed. Many of them have been cited and decorated for great bravery and heroism under fire and others for distinguished service in other ways.

The Annual Distinguished Service Medal of the American Medical Association was awarded to Dr. George R. Minot of Boston. His great contribution on the cause and control of pernicious anaemia is known and acclaimed through the civilized world. Thousands of people today live and work in relative safety and comfort as a result of this discovery. His associates, Dr. William P. Murphy and Dr. George H. Whipple, have contributed greatly to this work also.

An important committee to investigate the problems of the Medical Officer in time of war and to critically review the many letters received at American Medical Association Headquarters from medical officers the last few years was appointed. It is believed that this committee will serve a valuable purpose and that from it may come some very much needed suggestions for the Military Services should another war arise.

Perhaps the highlight of the meeting was the address of Major General Paul R. Hawley, M. C., U. S. A., Chief Medical Director of the Department of Medicine and Surgery of the Veterans Administration. General Hawley spoke frankly and forcefully of the plans for reorganization of the Medical Service of the Veteran's Hospitals. He is apparently determined to bring the best possible medical care to veterans and proposes a plan which should prove attractive to physicians who might be interested in institutional work. Graduate work is to be emphasized. Men are to be judged on ability, training and conduct. Certification by specialty boards is encouraged both by opportunities to study and write, and by a 25% cash bonus on basic pay for men who qualify. In the Journal of the American Medical Association for January 5, 1946, on page thirty-two an excellent review of this notable address is available.

The South Carolina Medical Association needs fewer than fifty new members to rate two delegates annually. In the momentous problems ahead we need all the help available. Let's bring our State membership over the thousand mark and I hope every member will subscribe to the Journal of the American Medical Association, undoubtedly the greatest Medical Journal published today.

Dr. Brockman: You have heard the report of Dr. Smith. Are there any questions? (None)

(Photograph made at this time by newspaper photographer.)

Dr. Brockman: We will now hear from the Chairman of Council, Dr. Bob Durham.

Dr. Durham: The Council had a meeting before this assembly gathered and passed two resolutions. First, we have something to give you. The State Health Officer will explain that. The second item, we are taking a thousand dollars away from you. Dr. McDonald from Rock Hill will go into that. As far as I know, since the last meeting everything has been going along smoothly.

Dr. Wyman: (Recognized by the Chair)—The American Red Cross has advised the State Board of Health that they have a surplus of dried blood plasma beyond the need of the Army and the Navy. It came from the American people and they want to give it back to the American people. The American Red Cross and the local chapter of the American Red Cross must have credit for the part they played in gathering and processing this blood, and the people for giving the blood.

There cannot be any cost connected with it. You may charge for the administration of the plasma. It does not interfere with the practice of medicine.

WHEREAS, the American Red Cross accumulated during the war large quantities of blood given by the American people for the armed forces; AND WHEREAS, the amount of blood and plasma collected and processed was predicated upon the needs of the Army and Navy for a long and costly war; AND WHEREAS, because of an earlier cessation of hostilities than was reasonably expected in both the European and Pacific theatres, there is now in the hands of the Army, Navy, and American Red Cross a quantity of dried plasma which is in excess of their needs during the anticipated useful life of the plasma, namely five years from the date of processing; AND WHEREAS, the American Red Cross believes that this dried plasma should be made available to the civilian population through a proper method of distribution, using the numbers of practicing physicians, the population, and the hospital bed capacity as a basis for distribution; AND WHEREAS, it is the declared purpose in planning for distribution and use in civilian medical practice to include three factors which are believed to be of particular importance: 1) to assist in making possible an accurate

determination of the needs for blood and blood plasma in the various parts of the country; 2) to strengthen and stimulate the development of already established State and local blood and blood derivatives program; 3) to demonstrate the value of such programs and thus stimulate the establishment where they do not already exist; AND WHEREAS, the American Red Cross believes that there should be proper credit and proper publicity given to the Red Cross chapters and to the public about the part played by the American Red Cross and the civilian population in providing, collecting, and processing blood; AND WHEREAS, the South Carolina State Board of Health has been selected by the American Red Cross as the State distributing agency for dried plasma in cooperation and assisted by the Red Cross chapters of the American Red Cross, the State Board of Health to prepare proper methods of storage and distribution of the surplus dried plasma, making available to hospitals and physicians for use in the civilian population without cost or charge for the plasma;

NOW THEREFORE BE IT RESOLVED, That we approve the program sponsored by the American Red Cross as outlined in the preamble to this resolution; RESOLVED, FURTHER, That we, the governing board of the South Carolina Medical Association, agree, on behalf of the medical profession of the State of South Carolina, to use and make available dried plasma without charge for storage, distribution, or the product itself to the civilian population of the State; RESOLVED, FURTHER, That we agree that in the distribution and use of the dried blood plasma that proper records will be completed and made available to the State Board of Health as State distributing agency and the American Red Cross.

Dr. Brockman: This is something your Council has passed and Dr. Wyman feels like he would like this House of Delegates to approve this plan of distribution of the plasma by the State Board of Health.

(The motion made, seconded and carried.)

Dr. MacDonald: (Recognized by the Chair.) I have had something on my mind for a long time. The present Wagner-Murray-Dingell Bill was what prompted the resolution I asked to be adopted. A member of the National Congress in South Carolina asked me why the SCMA did not have some definite plan through which the members of Congress could call on and get some information. So, I offer this resolution.

BE IT RESOLVED, that the South Carolina Medical Association under the leadership of the Secretary and the Director of Public Relations, institute immediately an intensive program toward the education of the public (through public addresses, the press and the radio) concerning President Truman's National Health Program and the Wagner-

Murray-Dingell bill, and

BE IT FURTHER RESOLVED, that Council be instructed to appropriate the sum of \$1,000.00 to be used for this purpose.

The general population are not aware of the Wagner-Murray-Dingell Bill, and I feel that they should be informed. Buy some radio time. Have some men who are good public speakers. Jack Meadors, our Public Relations Director, and Julian Price, have done a wonderful job. I feel that we should help them. We should get a certain number of men who could be called on to speak before service clubs, etc., any kind of organization that will listen. We can go a long way toward informing the people of South Carolina what we are up against. That is the resolution I offered before Council, and I move that the state association have \$1,000.00 appropriated for it.

Dr. Brockman: You have heard the motion with reference to the Wagner-Murray-Dingell Bill, and that the state association appropriate the sum of \$1,000 for the education of the public regarding this measure. Is there any discussion?

Dr. Price: We have the money in the treasury at the present time, and if the dues for the coming year are paid, we can still carry on our Ten Point Program and do this, too.

(Motion seconded and passed.)

Dr. Brockman: We are going to hear now from one who has done a fine job. He certainly has worked hard, and has gotten out of a sick bed to make this report. Dr. James McLeod, Chairman of our Medical College Expansion Committee.

Dr. James McLeod: Mr. President, gentlemen, this is, in my opinion, a most important meeting of our House of Delegates because it is one that is capable of doing much in a constructive way for the medical profession of South Carolina. As our distinguished and far-sighted President just pointed out in his opening remarks, this meeting today is not confined to the delegates, but is thrown open for free and full discussion by each member. I wish to heartily endorse his suggestion, since what is about to be brought before you is of vital interest and concern to each and every member.

This is a fine attendance. Your very presence is symbolic of your intense and deep interest in organized medicine and medical education and in the progress of medicine in South Carolina. As Dr. MacDonald has pointed out, the preservation of medicine in the United States is at the cross-roads. One road leads to government medicine and ultimate regimentation. The other road leads along the same path uphill that this profession has always trod, a path of freedom of effort in a free country. A free and unhampered profession has done much for the citizens of this state and this country. As a matter of fact, our last freedom has just been won,

as you know, at the expense of a million casualties. We did not win this war for regimentation. We expected that under Hitler, not under a victorious stars and stripes. There is no question that the medical profession is capable of realizing the condition of the health of the people of the state and the nation, and that the medical profession is the best informed body in the State of South Carolina as to what is needed in the line of medical education and medical care.

It is my sincere opinion that if this group of men thinks the facilities at the Medical College are adequate and that no change should be made, then no change should be made, because I think that we are more capable than any other group of determining what is necessary and what is needed in medical care and education. If this group assembled here today feels that the facilities are not satisfactory, adequate facilities will be provided. If the profession will become properly aroused, you can get just what you want. You represent the finest and highest type of citizen. If this group feels that our facilities are not satisfactory, there is no question about the fact that satisfactory facilities will soon be provided. It was my privilege to be present at the zero hour when the Medical Education Program Bill failed to pass. It is no reflection on those people who did what they could for you, for your profession and for medical progress in South Carolina. I was present in that group. The reason it failed to pass was not because of the merits of the program, but because the members of this Association were not properly informed and did not properly understand what the program was about. I was convinced and had confidence in the physicians of the state that if they were properly informed, they would become aroused and see that medical progress in this state was what it should be.

At the meeting of the House of Delegates last Oct. 2, 17 men, one from each Judicial Circuit, together with the President, the Secretary and the Director of Public Relations, were appointed, to study the Medical Expansion Program and see if it was necessary, to see what was needed in Charleston or in South Carolina. The committee went to work and I wish to tell you men that they have worked hard. Four meetings were held. At the first meeting in Columbia we took the so-called Medical Expansion Program and studied it. We found that the members of our own committee did not know what was going on. We spent all afternoon, and we made plans to go down to Charleston about 10 days later. We made an inspection of the Medical College, Roper Hospital and all facilities contained there. We heard the whole Charleston County Delegation, representatives from the Charleston Chamber of Commerce, Charleston was aroused. For some reason or other, Charleston thought they were going to lose the Medical College. They knew the facilities were inadequate. We met with them for over an hour. Dr. Robert Wilson, Dr. Lynch, representatives from

Roper Hospital, and others, were in session with us for about two hours. We went into every detail of what was needed there. We met next in Columbia at Senator Joe Berry's request, with the Richland County Delegation, who advocated the movement of the Medical College from Charleston to Columbia. They made an excellent showing. They worked hard. They showed the advantages of Columbia as a medical center. They recognized that there had to be a change in the medical college—that something had to be done. We went back into executive session that same day and the vote was unanimous that Charleston was the place for the medical college. We RECOMMEND that we do NOT move the medical college, because of its rich heritage and tradition, the present establishment there, and the tremendous cost involved in moving it. The committee of 17 feels that it should remain in Charleston and we so recommend.

After that meeting, Dr. Price and Mr. Meadors sent questionnaires to members of the committee for study over a period of two weeks. So we met back here in Columbia about two weeks later. We had an all-afternoon session. We also had the privilege of hearing an "off the record" report by one of the most distinguished medical authorities in the United States. He went much further in his report and stated that expansion was absolutely imperative. We went back into executive session. We concluded that the Expansion Program is not only necessary but that it is imperative if we are to continue medical education and progress in this state. This committee endorses to the House of Delegates and to the Members of the SCMA this Expansion Program, because we have studied it in every detail. The members of the faculty are right. Unless something is done in Charleston to provide better facilities, if we are going to continue a medical college, we *must* provide it with the proper facilities, or it should be closed up. We members of this committee recommend this program for enthusiastic endorsement, and by all—not by your distinguished President and one or two friends, but by the entire association.

The Committee of Seventeen also recommends that we continue as a committee. Do not misunderstand. We became interested, and I was asked to bring before this House the recommendation that we continue the Committee of Seventeen, and that the committee be empowered to expand itself to include a delegate from every county, to be known as a Special Legislative Committee, to assist and properly inform the members of the legislature from the various counties that this vital program will not be shackled and impeded as it has been in the past.

Men of the South Carolina Medical Association and of the House of Delegates, it is my sincere opinion that this is your great opportunity. If you enthusiastically endorse this program with deep, earnest, honest effort, it will go through. There are doctors in the Associa-

tion who may differ from the report that this committee is bringing you today. In that difference I have no condemnation whatever. But when this program goes through, my opinion is that those differing today, real men that they are, will put their shoulders to the wheel and give this program their endorsement and action, which they are capable of doing. This committee is not backing anyone. We are not opposing anyone. We are just backing medical progress and education in South Carolina. It is up to you men to become aroused as to what is needed. If you will do that, you will see in Charleston what should be there—an expanded medical college, expanded and alive, that you can point to with pride. It is a challenge to you men. I am sure you will meet it.

It was moved that the report of the Committee of Seventeen be adopted and this was seconded.

The motion was discussed by Drs. Carl Epps, Hugh Wyman, James Young, J. H. Gressette and D. L. Smith, Jr.

The motion was adopted by unanimous standing vote.

Dr. Ben Wyman was called upon to state the present situation as it pertained to a hospital survey for the state. He discussed the three possible methods of having the survey made: (1) State Planning Commission, (2) Special commission to be created by the Legislature, (3) State Board of Health with Advisory Committee.

After a discussion which was participated in by Drs. W. T. Brockman, J. P. Price, W. R. Wallace and James Porter, the following resolution was submitted by Dr. J. D. Guess:

Resolved, that this House of Delegates disapprove of the plan to have a hospital survey made by the State Planning Commission and the plan to sponsor a new commission, and that this House of Delegates approve of the plan which calls for a hospital survey to be made by the State Board of Health with the help of an advisory committee and,

Be it further resolved, that this House of Delegates endorse the bill now in the General Assembly which would provide for such a survey to be made by the State Board of Health.

This resolution was seconded and passed.

Dr. J. D. Guess, Chairman of the Scientific Committee, made a brief report.

Dr. J. P. Price, Secretary, made certain announcements relative to the annual meeting in Greenville, April 30, May 1 and 2, and other matters.

There being no further business the meeting was adjourned.

Total attendance at the meeting (delegates and members of the Association) 150.

J. P. PRICE
Secretary

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price			Florence, S. C.		
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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) ----- Florence, S. C.
Subscription Price ----- \$3.00 per Year

FEBRUARY, 1946

STATE MEETING PROGRAM

The Scientific Committee of the State Medical association is rapidly shaping up the scientific program for the annual meeting in May. Plans with which the scientific program will be correlated include a banquet on Wednesday night with an outstanding speaker whose subject will not be actually medical. The ladies will be invited to the banquet. The alumni luncheon will also be on Wednesday. The scientific session will convene on Wednesday, May 1, and will close Thursday, May 2, at 1:00 P. M. President Brockman has secured three outstanding out-of-the-State guest speakers whose subjects will come from proctology, general surgery and obstetrics. These and the president's address will be special order features, two on Wednesday morning, one Wednesday afternoon and one Thursday morning. The session will close with an obstetrical round table, at which time prepared questions and questions from the floor will be discussed.

The committee wishes seven papers by members of the association. They must not exceed fifteen minutes reading time. Please submit your title together with a very brief summary of your paper. This should be done promptly.

J. D. GUESS, M. D., Chairman,
Scientific Committee.

200 East North Street,
Greenville, S. C.

BLUE CROSS IN ACTION

At long last Governor Williams has signed the Blue Cross Bill which was passed by the General Assembly last year. We have never understood the Governor's delay in affixing his signature to this bill.

At this writing plans are going forward toward organizing a state wide hospital service plan. It is hoped that by the next issue of this Journal a detailed discussion of this project can be made.

Our Medical Association had a large part to play in bringing a hospital service plan of this type to South Carolina and we wish to commend all of those who participated in this project. Particularly, do we wish to congratulate Mr. Jack Meadors since it

was under his leadership that the work was done.

We extend to the board of directors of the new organization—whoever they may be—our heartiest wishes and our pledge of support as they embark upon this new venture. We feel that a Blue Cross plan is one of the greatest needs of the people of South Carolina today and we will bend our every effort to speed the work which is waiting to be done.

IN ST. LOUIS

It was the privilege of Dr. James McLeod, President-Elect, and the Secretary of the Association to represent South Carolina at a gathering in St. Louis on January 18 and 19. This meeting was held under the auspices of the National Physicians Committee and was composed of two representatives from each state.

The object of the meeting was that of education—to acquaint every member present with the details of proposed legislation in the Congress, with particular reference to the Wagner-Murray-Dingell Bill and the Pepper Bill. It is essential that the various state medical associations be in a position to give their Congressman the benefit of their suggestions and advice and also to be ready to appear at the committee hearings in Washington when the bills come up for consideration.

The meeting was highly instructive. It now becomes the duty of the President-Elect and Secretary to convey this information to the members of this Association so that they too may become fully aware of what is being considered in our National Congress.

A DECISION MUST BE MADE

The halls of Congress, which have witnessed so many battles, will soon be the scene of a mighty struggle which each physician will watch with more than usual interest. Unless we are mistaken, the American people will soon decide through their chosen representatives the type of medical care and medical practice which they desire for themselves and their children.

The immediate issues at stake will be the Wagner-

Murray-Dingell Bill and the Pepper Bill, and it is around these proposals that the battle will be fought. The underlying and fundamental issue, however, will be the role which Government should play in the practice of medicine.

As we see it, the people of this nation must make a choice sooner or later—between two broad principles; (1) the practice of medicine should be controlled and administered by the Government, or (2) the practice of medicine should be controlled and administered by private enterprise. Various plans (i.e. the Wagner-Murray-Dingell Bill) have been proposed which would appear, on superficial examination, to effect a compromise between these two principles incorporating the better features of each. But such is not and cannot be the case. There must be a final authority in medical practice. So far, in this country, it has been in the hands of private enterprise. The Wagner Bill—and allied plans—would place it in the hands of Government.

A decision must be made—and the ones to make it are the American people.

WHAT SHALL WE DO?

If the members of our Association are convinced—and we believe they are—that the Wagner-Murray-Dingell Bill and other proposed legislation of a similar nature are inimical to the best interests of our people and of our profession, what shall we do toward preventing their enactment into law.

On the basis of experience and of discussions with medical leaders in this and other states, we present the following suggestions as to a plan of action.

1. Study.

No physician would consider participating in a symposium on some medical subject without thorough preparatory study. Yet there are many physicians who seem ready to enter into a public debate on bills now pending in Congress who have never read, even casually, the matter under consideration.

An analysis of the Wagner Bill has been published in this Journal and in the Journal of the American Medical Association. Copies of the Bill itself may be secured from one's local Congressman.

2. Education.

After his study, we suggest that each physician

begin an intensive program of education. Patients and social acquaintances afford a fertile field for sowing of the seed. Congressmen need education also. Beset as they are with a mass of proposed legislation, they have little time for careful consideration of each bill. They should be given the benefit of suggestions and opinions of those who know whereof they speak.

3. Action.

The final decision regarding the future course of medical practice rests with the American people. Through their representatives in Congress, they will register their votes. It is vital, therefore, that every Congressman know the will of his constituency. To accomplish this with respect to the Wagner-Murray-Dingell Bill, it becomes essential that each physician stimulate those in his community to communicate with their Congressman on this matter. It is also important that each physician make his personal opinions known.

Study, education, action—these are the three steps which we urgently suggest to each member of our Association.

JAMES ADAMS HAYNE

A worthy tribute was paid to one of the great medical leaders of South Carolina when the Columbia Medical Society, at its January meeting, presented Dr. James Adams Hayne with a silver pitcher and tray. Dr. William A. Boyd, in presenting the gift, told of the splendid work of Dr. Hayne in the field of public health in this state and of the courageous leadership which Dr. Hayne had given in this phase of medical welfare.

Although Dr. Hayne has now retired from active leadership as State Health Officer, he is still active in mind and body and this was never more evident than in his response to Dr. Boyd. During the course of his remarks he mentioned the fact that this year completed fifty years of medical life, since he was graduated from medical college half a century ago.

The Journal wishes to join with the Columbia Medical Society in thanking Dr. Hayne for what he has done for South Carolina, in congratulating him upon the place which he now holds in the affection of his colleagues throughout the state, and in wishing for him many more years of active and joyful living.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

GOVERNOR SIGNS BLUE CROSS ACT

On January 10, 1946, the Governor signed the Blue Cross Act adopted at the last session of the legislature and it became law. At long last, South Carolina can join the ranks with the vast majority of the states in organizing a non-profit hospital

service plan. According to reliable information, the efforts of the opposition to have the Governor veto the measure continued up until the very last. In fact, on the opening day of the session, a motion was made by Senator Berry of Richland County to withdraw the Act from the desk of the Governor.

ostensibly for the purpose of making amendments which would improve the measure. According to newspaper reports, however, the senator was informed from the Senate Desk that such procedure was impossible. This is certainly what we would have thought, and it is surprising that the senator from Richland, who has occupied a seat for the better part of a four-year term, should not be aware of the fact.

In transmitting the bill, the Governor made a request that those interested postpone setting up any organization under the Act for a period of approximately six weeks in order to allow the opportunity for certain amendments which he indicated he thought were necessary or desirable, to be introduced and acted upon. In all probability, completion of the plans for organization will require five or six weeks, and the Governor's request will doubtless be complied with willy-nilly. At the same time, the original sponsors of the movement in South Carolina are not waiting idly for the time to pass. They feel, perhaps with just cause, that sufficient delay has already ensued since the legislature passed the Act. We are entirely satisfied, as we have been all the time, that the act, while perhaps not entirely perfect, contains no glaring defects or dangerous provisions. We are glad indeed that the Governor by his action, however belated, has indicated his agreement with that view, in thus placing his stamp of approval on the measure. We hope in next month's issue to be able to report material progress toward the setting up of the organization.

PENDING BILLS

Just to bring our readers up to date, it may be well to review briefly the legislative progress of the various bills in which the profession is interested.

The Wagner-Murray-Dingell Bills most recently introduced, embodying the President's proposals for a National Health Program, were referred to the Committee on Education in the Senate, and to the Committee on Interstate and Foreign Commerce in the House. Although it was rumored that public hearings would be started by one or both of these committees shortly after the reconvening of Congress, latest reports are that no date has been set and no definite move made in this direction to the present time. It is believed that the pressure of more vital legislation pending before Congress, the superior importance of which is recognized by the lawmakers, is responsible for the delay. The Chairmen of the Committees have stated, we are informed, that they intend to give the bills hearings as soon as this can be arranged.

Attention is called also to the fact that the first edition of the 1945 version, termed Social Security Amendments of 1945, are likewise still in committee. These, also Wagner-Murray-Dingell Bills, were referred to the Finance Committee in the Senate (S.1050) and to the Ways and Means Committee in

the House (H.R. 3293). It is believed by some to be entirely possible that these committees may give the bills before them a hearing.

Attention has been called to the fact already in this Department (December, 1945) that the bills introduced in November were very similar to S.1050 and H.R. 3293, so far as the provisions for compulsory health insurance are concerned. While it may be true that further consideration will be given to the earlier bills, and of course they should not be lost sight of in following the trend of developments in Congress, it is our belief that no important effort will be made to secure their adoption, and it is very doubtful whether the committees to which they are referred will hold public hearings. As we pointed out in the December issue, there are certain things connected with the bills introduced in November calculated to make them appeal more to the people generally than the former Wagner-Murray-Dingell bills and, backed by the force of Presidential influence transmitted through his message to Congress at the time these bills were introduced, they are the logical ones to be pressed.

The Hill-Burton Hospital Construction Bill (S.191) passed the Senate after considerable amendment, in December, and after going to the House was referred to the Committee on Interstate and Foreign Commerce of that body on December 12th. It is reported that the Committee will likely hold hearings on the measure during February.

No report has been received recently on the bill to provide Maternal and Infant care to all women and children in the nation, which bill (S.1318) was introduced by Senator Pepper and nine other members of his committee, some months ago. So far as can be learned, there is little prospect of immediate progress for the measure.

A YEAR FOR ACTION

As expressed in one of the recent News Letters from AMA headquarters, "1945 was American medicine's year of decision. 1946 is American medicine's year for action."

The letter continues by pointing out, "In 1945 the Fourteen Point Constructive Program for Medical Care was proposed by the Council on Medical Service and Public Relations, approved by the Board of Trustees, and sanctioned by the House of Delegates" in amplified form.

"Now 1946 must see this program put into action. That will be one of the chores of the Council. Two other tasks placed specifically on the Council by the House of Delegates are:

1. Organization and incorporation immediately of a National Health Congress representative of the medical, dental, hospital, nursing, pharmaceutical, and allied professions.
2. Development of a specific national health program, with emphasis on the nationwide organiza-



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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

tion of locally administered prepayment medical plans sponsored by medical societies."

Description of the proposed national health congress referred to above was carried in last month's issue, that is, of the organization as proposed by those who originated the idea. We assume that the plans under consideration by the Council on Medical Service and Public Relations will follow the same pattern but, of course, there may be changes.

The communication from the Council emphasizes the fact that there should be no diminution in the efforts and progress toward organization of state and other local medical service plans. "Development of local and state voluntary prepayment plans should be stepped up a pace rather than slowed down as a result of the action of the A.M.A. House of Delegates providing for the establishment of a national health insurance program. Word has come that work on several local plans has come to a momentary halt in anticipation of the national program as local groups apparently want to take a look-see at the A.M.A. proposals before going ahead with their program. This perhaps is only natural and logical but if continued it would tend to defeat the purpose of the action taken by the House of Delegates.

"As pointed out -----, development of a national over-all plan is difficult and some even believe a "well-nigh" impossible task. No matter how difficult the task, it is the definite, determined desire of the Council to present such a plan to the Board of Trustees, but it will take time for a specific program to be formulated. Hence, work on plans now being done by state and local societies should go forward. This is not a static problem but one as chock full of variables as an Einstein equation. The more varied these local plans are in form, the better this may be in the long run for the most workable, over-all master plan will come finally only through trial and error and evolution. This is the true scientific process. In fact here are the steps to be taken before a national program can be submitted to the public.

1. Formation of a plan by the Advisory Committee on Prepayment Medical Care of the Council. (This is being done by the Committee and it expects to be ready to make a preliminary report this month.)
2. Presentation of program for approval of the Council itself.
3. Presentation to Board of Trustees for approval.
4. Notification of the Societies of the plan.
5. Release of the plan to the public.

To complete each one of these steps even if all goes as smoothly as is hoped will take several weeks."

ACCENTUATE THE POSITIVE

Again, as has frequently occurred, we find the views of the Observer, which are so well expressed each month in the Medical Annals of the District of

Columbia, in line with our own. There is always a feeling of satisfaction and somewhat of reassurance to find one's views expressed by another, although expressed far better than one could do.

The following may be to a large extent repetition of what has been said here and elsewhere, but bearing in mind that "A drop of water wears away a stone, not by force but by continual dropping," we think the repetition will serve a useful purpose. The quotation is from the remarks of the Observer in the December issue of the Annals:

"Those who peruse this column from month to month have become familiar with your Observer's thesis that organized medicine must sponsor an adequate national health program without further delay if its voice is to carry any weight with the public. If it had been as diligent in furthering such a program as it has been in opposing proposals which it does not favor, there would be little cause for criticism. But its position has been negative rather than positive. Your Observer has presented many variations of this theme, but this is the essence of what he has had to say.

"Several examples of the negative approach might be given. At a recent meeting a representative of a medical society from a Southern state told of the employment of a public relations expert whose task it was to win public support for the society's stand against health legislation which it did not favor. There was little that was constructive in the program which he described. The society was simply "agin" everything. Your Observer, who was present, raised his voice in protest, stating that a negative position in these times would never do." (The above reference to a Southern State and employment of a Public Relations Officer gave us somewhat of a start at first, but we are confident that the writer could not have been referring to us because, first, we are not expert and, second, the Ten Point Program was one of the first constructive steps taken by the profession.)

He concludes: "But where the health of the people is concerned we must do more than find holes in the proposals made by those with whom we disagree. Let us continue to oppose what we sincerely believe is not in the public interest, at the same time offering what we feel will benefit the people most. If anything will stop 'reformers,' it will be a positive rather than a negative program."

"REPUTATION COMMENSURATE WITH CHARACTER"

"Public Relations" as a function of business or profession has lately begun to come of age. Public relations men themselves have come a long way from the time most of them were mere press agents engaged by sensational people to conjure up sensational news about them in the newspapers. The practitioners of public relations are now trying to give their calling a professional status by weeding out the

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- NEPHRITIS stood fourth in causes of death in 1942*.

This is one disease from which thousands could be saved if people were educated to visit their physicians for periodic checkups, because nephritis gives no warning symptoms in its early stages. A physician's thorough examination and tests would disclose the otherwise unsuspected nephritic condition.

To help in educating the laity in the importance of regular examinations, we have prepared a pamphlet — "Watch Your Health". Nephritis is one of the seven serious diseases explained in simple terms. Copies are available to physicians on request.

* U. S. Summary of Vital Statistics, 1942.

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fakers and phonies in their midst, by elevating and standardizing ethical behavior, and by improving the status generally of public relations in executive management.

That these objectives have to some degree been achieved is attested in an address recently by Claris Adams, retiring chairman of the Institute of Life Insurance at the annual meeting of the Institute in New York. Mr. Adams characterized public relations as a "major function of top executive management" and said that no institution serving the public could afford to neglect its lines of communication.

"Institutional statesmanship demands that no problem which may confront us shall be complicated by suspicions born of ignorance or enmity arising from misunderstanding," Mr. Adams said, "The objective of public relations is reputation commensurate with character. It contemplates that every function and operation of the company be scrutinized from the aspect of public interest. We must not forget that we are the agents and not the masters."

Mr. Holgar J. Johnson, President of the Institute, gave the matter a twist which may sound familiar to physicians when he said that a sound public relations program is one of the best ways "to meet the growing trend toward socialization throughout the world."

Medicine, along with most other fields of endeavor is belatedly giving attention to the importance, in fact the vital urgency, of taking the public into its confidence and of earnestly and sincerely seeking the public prestige and support which it truly deserves.

(From New York Medicine, January 5, 1946)

NOT TIME FOR THE JITTERS

The following extract from an editorial which appeared in the Ohio State Medical Journal for December, 1945, expresses in large measure ideas that we have held for a long time. We have made attempts on occasion to give expression to the same general thought, but perhaps have failed to do so as effectively—or at least in quite the picturesque manner—as is done by this writer:

"Physicians are tired, physically and mentally. Some of the problems growing out of the war and looming large in the reconversion period have them confused and disturbed.

"The net result is that a lot of the docs are jittery and restless. Some of them are so upset that they want a change in everything without just knowing why. Some of them want to take a swing at everything and everybody; some want to curl up and hibernate.

"All of them are partially right; partially wrong, in our opinion.

"There is no sense in getting the jitters so badly that one loses his sense of values or his ability to act intelligently. There is no sense in wanting to change everything, slicing here and slicing there, without knowing why; where it will lead. There is

no sense in becoming so pugnacious that one falls into the trap of becoming a habitual opposer, never taking affirmative action on anything.

"The situation is not nearly as hopeless as a few think it is. The spirit and enthusiasm shown by the great majority at the November 11 meeting indicate that there is still plenty of life left in the medical profession; plenty of ability; plenty of guts.

"And don't forget, also, that the medical profession has a potent organization—one which can pack a real punch—if every member will get in and do some packing. Many times the fellows who do little, if any, packing and pitching are the very ones who want to start a revolution or want to curl up and die, believing that everybody's going to Hades in a basket anyway.

"Straight thinking, with courage and initiative to back it, is what the medical profession needs—must have—in these days. It needs more members like the devoted and interested men and women who came to Columbus on November 11—not because they had to, but because they wanted to. They are the spark plugs. But, don't forget, they can't carry the whole load."

The meeting in Columbus referred to in the above was a conference of the County Society Presidents and Secretaries of the State of Ohio. A few weeks ago we attended (at their invitation and expense) a conference of County Secretaries in Indiana, an annual meeting held in Indianapolis, and we have been thinking that such an organization in South Carolina might be in order. Our state is not as large as either Ohio or Indiana. It is not divided into as many counties—not by a wide margin—but it is large enough and the county societies sufficiently numerous to make such an organization worthwhile.

We have seen in the past few months and, in fact are still witnessing, the results obtainable through coordinated action of representatives of the profession from over the state, in connection with the Medical College Expansion Program. An organization of the county secretaries, or all the officers of the county societies, would provide a basis for coordination of all the efforts which will be made by the doctors in the state within the next few months and in the years to come. It would serve to stimulate interest and activity by the county societies in connection with problems other than the scientific practice of medicine.

We advance this suggestion and would like to have our readers (if any) think it over.

ANOTHER VIEW ON PUBLIC RELATIONS

Organized medicine can learn something about public relations from industry. We can apply some of their techniques.

The best public relations man in industry is the salesman. The good salesman sells his product honestly. He also sells the organization he represents

More pleasure to you, Doctor!

THREE nationally known research organizations recently reported the results of a nationwide survey to discover the cigarette preferences of physicians and surgeons.

Physicians all over the United States were asked the simple question: "What cigarette do you smoke, Doctor?" The question was put solely on the basis of *personal preference as a smoker*.

The thousands and thousands of answers from these physicians in every branch of medicine were checked and re-checked. The result:

More physicians named Camel as their favorite smoke than any other cigarette. And the margin for Camels was most convincing.

Certainly the average physician is busier today than ever before and is deserving of every bit of relaxation he can find in his day-by-day routine . . . a cigarette now and then if he likes. And the makers of Camels are glad to know that physicians find in Camels that extra margin of smoking pleasure that has made Camels such a favorite everywhere.

According to this recent nationwide survey:

**More Doctors
Smoke Camels**
than any other cigarette



on a basis of its integrity and its product.

The best public relations men in organized medicine are the private practitioners. If they practice honest medicine and express their honest, substantiated opinion during this critical period, they, as individuals, can guide public opinion in favor of organized medicine more effectively than any organized group.

The future of medicine depends upon the attitude and activities of the private practitioners of medicine. If the private practitioner assumes an attitude of indifference or a quiet confidence in our superiority in the belief that the rest of the world believes in our superiority, he is practicing poor salesmanship and poor public relations. Many of our citizens, despite their respect for their family physician, lack faith in organized medicine and in the superiority of the profession in determining the future medical needs of our people. The public must be convinced of our superiority.

Remember, it is public opinion, not the opinion of the medical profession that determines national policies.

(The Journal of the Medical Society of New Jersey.) December, 1945.

COMMITTEE WORKS ON RELOCATION PROBLEM

The Committee on relocation and placement of returning medical officers, authorized in the House of Delegates meeting on Oct. 3rd, 1945, has been about its work several weeks. Headed by Dr. W. L. Pressley as Chairman, with his great fund of experience as head of the Procurement and Assignment Service in South Carolina, the committee drew up a list of doctors in each of the counties in the state, one being selected in each county, who were re-

quested to act as contacts between the central committee and the county medical groups. These 46 doctors were asked to advise the secretary of the committee of any place in their respective counties where there is an opening for a doctor and the type of medical service that is particularly needed. He was asked to designate whether the need, if present, is for a general practitioner or, if for a specialist, the type required. He was asked to furnish the information not solely upon the basis of his own opinion, but after consulting with other members of the profession within his county and within the communities concerned.

The committee is proceeding entirely upon the policy of obtaining such information from the local physicians themselves. Its advice to returning members of the profession desirous of finding location will be based upon the need as reported by the physicians in the communities in question.

There has been considerable response to the effort to obtain the information as above outlined. There are quite a number of the 46 doctors to whom we wrote from whom we have received no reply. We take it that those who have not responded have found no need or potential need in their counties, and we are led to this conclusion more strongly by the fact that in most of the replies which were received there are reports of definite needs for new men to fill vacancies now existing or potential. All of this information is channelled through our office to the Chairman. Dr. Pressley receives through other channels and in many cases directly from the men themselves, information as to the medical officers being discharged and seeking relocation or placement in South Carolina. There is no way to estimate at this time the extent of the progress or value of the work which the committee has undertaken. No doubt, the results will justify the effort being made.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. Vance W. Brabham, Orangeburg, S. C. Publicity Secretary: Mrs. P. J. Boatwright, Orangeburg, S. C.

ANDERSON COUNTY MEDICAL AUXILIARY REORGANIZED

The Woman's Auxiliary to the Anderson County Medical Society was formed on November 15 at a called meeting of the doctor's wives of the county at the home of Mrs. Olin Hentz on the Boulevard.

Inspirational talks were given by Mrs. Vance W. Brabham, president of the State Medical Auxiliary, from Orangeburg; Mrs. David Adeock, first vice-president of the Auxiliary, of Columbia; Mrs. H. L. Timmons, legislative chairman of Columbia; and Mrs. William Folk, counselor of the district, from Spartanburg. The purposes of the Auxiliary were set

forth, and the advantages brought out of having such an organization.

It was voted by the ladies present to reorganize.

Mrs. S. Harry Ross was elected president and a constitution committee composed of Mrs. W. H. Nardin, Mrs. Louis Gray and Mrs. J. R. Young was elected to work out the by-laws of the Auxiliary.

The next meeting will be held at the home of Mrs. J. R. Young and the wish is expressed by all members that all doctor's wives and widows in Anderson County will join them in what they believe will be a most successful organization.



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NEWS ITEMS

Dr. Olin B. Chamberlain has returned from the army where he attained the rank of colonel and has resumed a position on the faculty of the Medical College of the State of South Carolina. He has been elected by the board of trustees to the full-time professorship of neuropsychiatry.

Dr. Joseph H. King has opened his office for practice in Manning. Dr. King recently received a discharge after serving two and a half years in the Mediterranean theater.

Dr. T. D. Dotterer has received his discharge from the army and has re-opened his offices in Columbia for the practice of pediatrics. Dr. Dotterer was a Lieutenant Colonel at the time of his discharge.

Dr. J. R. Allison (Columbia) has taken Dr. Ned Rubinowitz in partnership in the practice of dermatology.

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation announces that the annual prize contest will be conducted again this year. For information address: Dr. Jas. R. Bloss, Secretary, 418 11th Street, Huntington 1, W. Va.

GENERAL LULL LEAVES SGO FOR AMA

Major General George F. Lull, Deputy Surgeon General of the Army, whose notable record in that capacity won him the Distinguished Service Medal, the highest noncombatant award, has retired from the Army after 33 years of service with the Medical Corps.

General and Mrs. Lull will move to Chicago, where General Lull will become Secretary and General Manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, the present Secretary and General Manager, becomes effective, but

he will immediately join the staff of the American Medical Association to familiarize himself with the work of the organization.

The citation for the Distinguished Service Medal stated that, in his capacity as Chief of the Personnel Service, General Lull was largely responsible for the development of policies and studies which resulted in outstanding achievements in the Army's medical program.

Early in World War I he commanded a base hospital at Camp Beauregard, Louisiana, and later organized and commanded Base Hospital No. 35 of the A.E.F. From 1922 until 1926 General Lull was Director of the Department of Preventive Medicine at the Army Medical Center. In 1929 he was appointed Medical Advisor to the Governor General of the Philippine Islands, where he served for three years. He had charge of the Vital Records Division of the Surgeon General's Office from 1932 to 1936.

The following four years he was Director of the Department of Sanitation at the Medical Field Service School, Carlisle Barracks, Pennsylvania. In 1940 he returned to the Surgeon General's Office as Chief of Personnel Service until May 31, 1943, when he was appointed Deputy Surgeon General.

Born in Pennsylvania March 10, 1887, General Lull received his M. D. degree from Jefferson Medical College in 1909, a Certificate of Public Health from Harvard Technology School of Public Health in 1921, and his degree of Doctor of Public Health from the University of Pennsylvania in 1922. He is an honor graduate of the 1913 class of the Army Medical School.

MEDICAL SOCIETY OFFICERS FOR 1946

The following officers have recently been elected: Columbia Medical Society: President, Dr. A. T. Moore, Columbia; Vice President, Dr. J. McMahan

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Medical Society of South Carolina (Charleston): President, Dr. M. W. Beach, Charleston; Vice President, Dr. A. E. Baker, Charleston; Secretary-Treasurer, Dr. Robert Wilson, Jr., Charleston; Librarian, Dr. H. R. Pratt-Thomas, Charleston.

Greenville County Medical Society: President, Dr. M. Nachman, Greenville; President-Elect, Dr. J. W. McLean, Greenville; Secretary, Dr. J. E. Crosland, Greenville; Treasurer, Dr. J. E. Lipscomb, Jr., Greenville, S. C.

Sumter County Medical Society: President, Dr. W. A. Stuckey, Sumter; Vice President, Dr. Charles White, Sumter; Secretary, Dr. Ragsdale Hewitt, Sumter; Treasurer, Dr. W. J. Snyder, Sumter.

York County Medical Society: President, Dr. J. L. Bundy, Rock Hill; Vice President, Dr. Ben N. Miller, Hickory Grove; Secretary-Treasurer, Dr. E. E. Herlong, Rock Hill.

Lexington County Medical Society: President, Dr. Karl L. Able, Leesville; Vice President, Dr. O. C. Holler, Leesville; Secretary-Treasurer, Dr. J. H. Mathias, Lexington.

PUBLIC HEALTH NEWS

STATE BOARD OF HEALTH TO DISTRIBUTE SURPLUS DRIED BLOOD PLASMA

County Health Departments to Be Distribution Depots

Dr. Ben F. Wyman, State Health Officer, has announced that an offer from the American Red Cross to make the State Board of Health the distributing agency for surplus dried blood plasma has been accepted and that tentative plans for distribution on a statewide basis have been made.

The plasma has been declared surplus to the needs of the Army and the Navy and it is the desire of the Red Cross to return it to the American people who gave the blood from which it was processed.

The initial allotment to South Carolina will be determined by the population of the State, number of licensed physicians and number of hospital beds. Subsequent allotments will be on a replacement basis and upon request from the State Board of Health.

Under its tentative plan, the State Board of Health will make available to all hospitals in the State that desire to participate in the program such quantities of plasma as can be pro-rated from the State allotment. The plasma allotted to a hospital will be for use of the patients hospitalized in that particular hospital.

All County Health Departments will be designated as distribution depots. They will distribute the plasma to practicing physicians in the State who may desire to carry plasma with them for administration to patients outside their hospital practice.

The State Board of Health will prepare and distribute educational material regarding the use of plasma to physicians and the general public through medical journals and the newspapers.

Immunization Procedures Recommended to Health Officers and Clinicians

At its December 12, 1945 meeting, the Executive Committee adopted a resolution recommending to the health officers and clinicians of the State Board of Health and the County Health Departments that they follow the type and sequence of immunization procedures approved by the Academy of Pediatrics as follows:

"1. Vaccination against smallpox at any age during an epidemic, but routinely any time between 3 to 12 months. Repeat at 6 and 12 years of age and during an epidemic. Revaccinate if necessary.

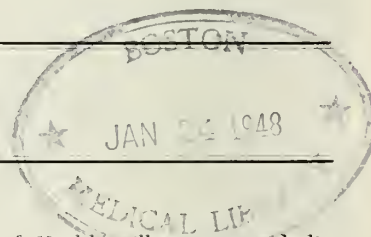
"2. Immunization against diphtheria between 9 and 12 months. Tetanus toxoid has been used in combination with diphtheria toxoid.

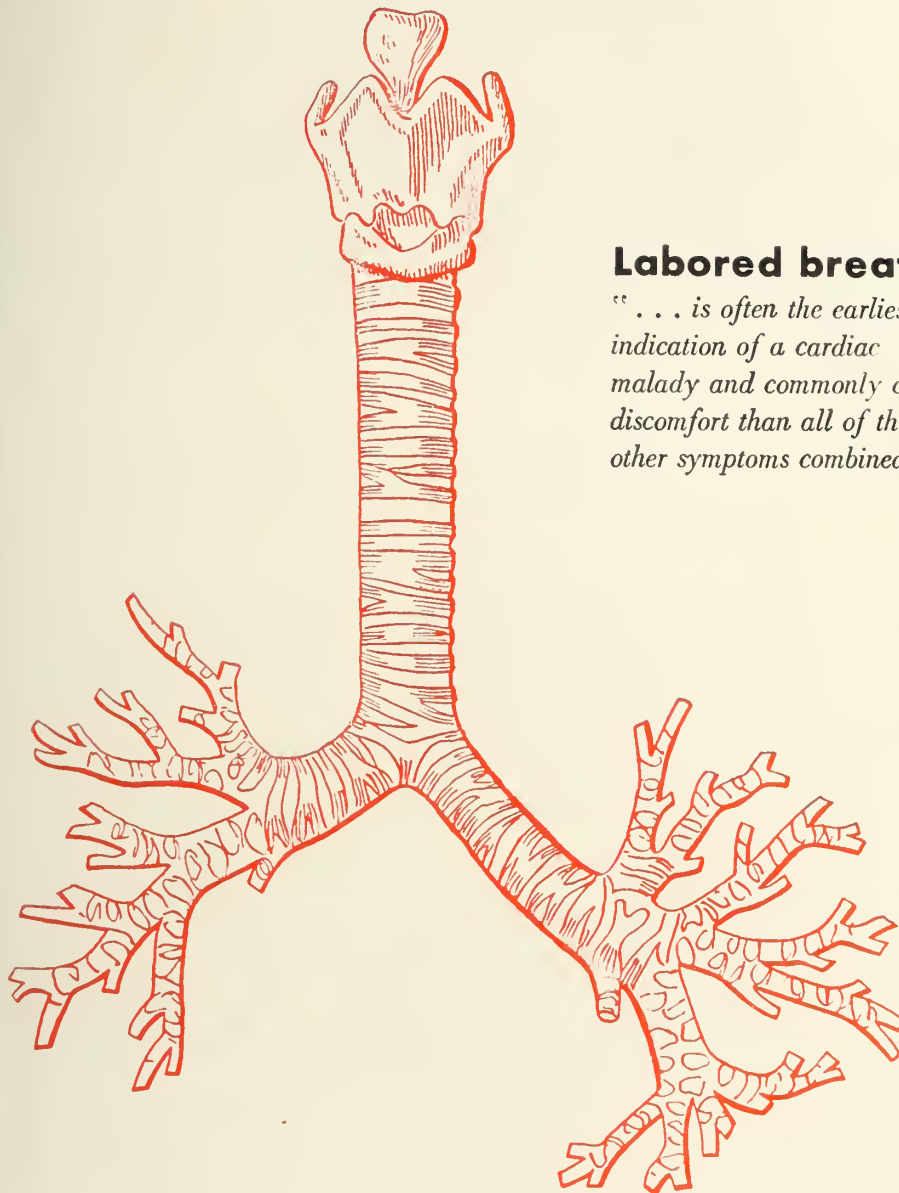
"3. Vaccination against pertussis at 4-9 months or at any subsequent time. It is questionable whether vaccination should be employed after 6 years of age.

"4. A Schick test given (or another injection of diphtheria toxoid) between 18 and 24 months. Re-immunize against diphtheria if necessary. Repeat the Schick test (or give another injection of alum precipitated toxoid) at 6 and 12 years.

"5. Tetanus toxoid may be given at any age period, but the reactions are not so severe if given between 2-6 years.

"6. Typhoid fever vaccine should be given at any age after 2 years—when and where it is indicated."





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1. Harrison, T. R.: Cardiac Dyspnea, Western J. Surg., 52:407 (Oct.) 1944.

South Carolina Medical Association

1945-1946

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The Journal of the South Carolina Medical Association

MARCH, 1946

VOL. XLII, NO. 3

CONTENTS

Medical Education in South Carolina—From a Survey Report to the Research, Planning and Development Board of South Carolina by the Division of Surveys and Field Services, George Peabody College for Teachers, Nashville, Tennessee.

Editorials — The Ten Point Program — News Items — Correspondence — Deaths — Public Health News

BACKGROUND

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1. New England J. Med. 228:118
(Jan. 28) 1943.
2. J. A. M. A. 129:613 (Oct. 27) 1945.



FINE PHARMACEUTICALS SINCE 1886

U P J O H N V I T A M I N S

OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA
Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879.
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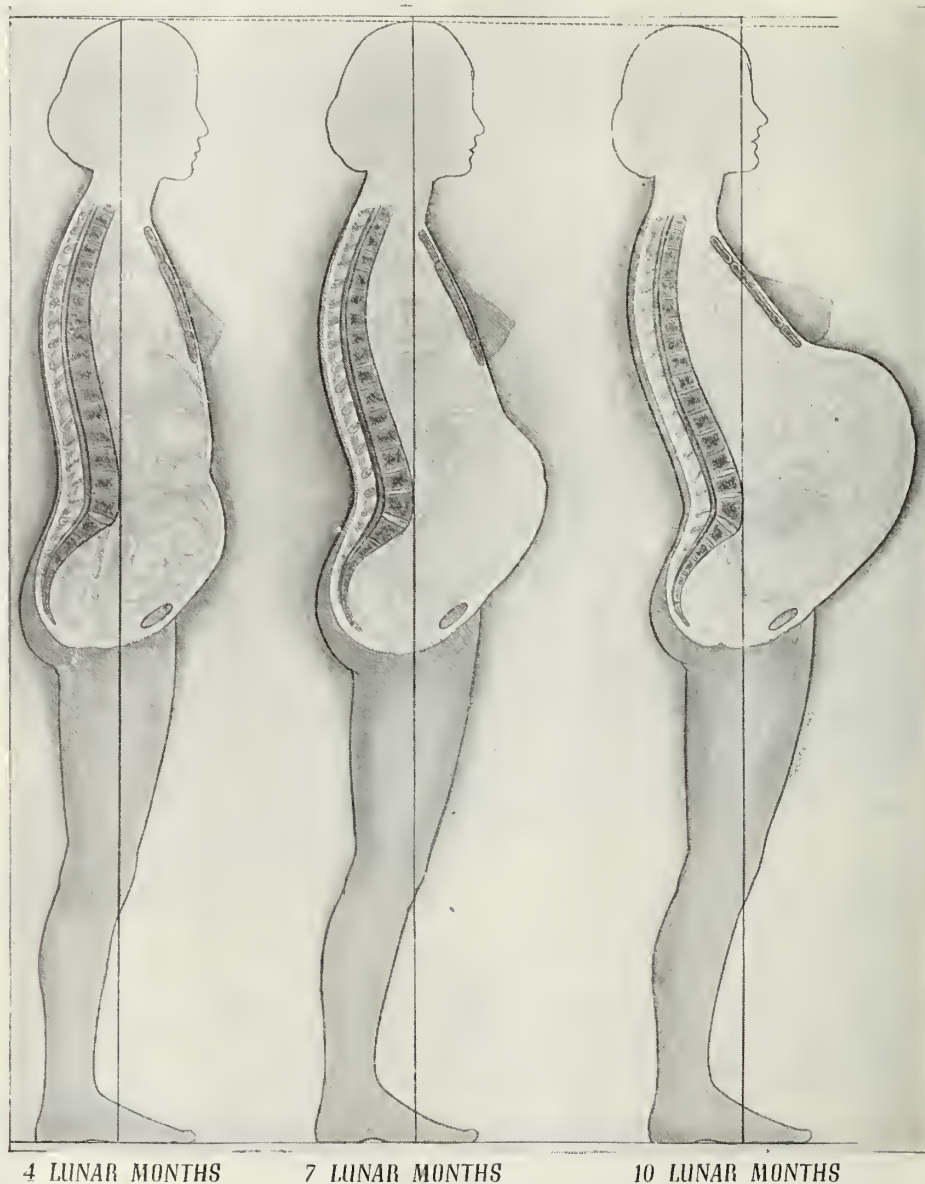
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THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

March, 1946

NUMBER 3

Medical Education in South Carolina

FROM A SURVEY REPORT TO THE

RESEARCH, PLANNING AND DEVELOPMENT BOARD OF SOUTH CAROLINA

By the Division of Surveys and Field Services, George Peabody College for Teachers, Nashville, Tennessee.

1946

(The survey of State tax-supported institutions of higher learning in South Carolina was undertaken by the Division of Surveys and Field Services at the request of the South Carolina Research, Planning and Development Board. Authorization by the South Carolina General Assembly for the survey of higher education was included in the Deficiency Appropriation Act, 1945, Section 3;

"The Research, Planning and Development Board of South Carolina is hereby authorized and instructed to procure a professionally recognized and competent staff to make a study and complete survey of the State tax-supported institutions of higher learning in South Carolina, including program and physical needs, giving detailed special attention to all phases bearing upon an adequate, efficient and progressive system of coordinated and unified higher education for the State.

"At the completion of this survey, the said Board shall publish the report of its findings for the public, and shall present the detailed findings to the General Assembly, together with proposed bills that will put the suggested program into effect."

The institutions of higher learning included in the survey were: The Citadel, Charleston; Clemson College, Clemson; Medical College of South Carolina, Charleston; University of South Carolina, Columbia; Winthrop College, Rock Hill; and State Agricultural and Mechanical College, Orangeburg.

We present, herewith, that section of the report of the Research, Planning and Development Board of South Carolina which pertains exclusively to Medical

Education. This section along with the rest of the report has been presented to the General Assembly.

This report not only endorses the Medical College Expansion Program as proposed by Dean Kenneth Lynch and his Advisory Committee—which was also endorsed by our House of Delegates at its special meeting in December—but goes well beyond it in making recommendations for the future. It is a well organized and presented statement of fact as to the conditions which exist in South Carolina and the need for future development in the field of Medical Education.—Editor)

In the very nature of the case medical education involves certain long recognized requirements, none of which can be waived. There must be well equipped and well staffed laboratories for (1) teaching and research; thorough clinical instruction, correlated with the medical sciences; (2) abundant clinical resources, both in-patients, or hospital cases, and out-patients, or those who are able to walk to the clinic for diagnosis and treatment; (3) clinical research as well as fundamental research in the medical sciences; (4) fully qualified teachers of all grades; technical and other personnel; (5) a high grade health service program for students; (6) comfortable and well located dormitories and dining facilities for students, if possible; and (7) acceptable housing for internes, hospital residents, students and graduate nurses, and certain other assistants who must live within the institution. Abundant cases for clinical instruction within all of the general and specialized fields of medicine and surgery, psychiatry, pediatrics, and obstetrics, must be available in prop-

erly distributed proportion to insure sufficient teaching material in each medical classification. This requirement involves convenient and especially designed out-patient and in-patient facilities *with special arrangements for teaching*. Excellently constructed and equipped hospitals, meeting all requirements for the modern care of the sick, may still fall far short of teaching essentials because of their design and arrangement.

To secure a continuing number of acutely ill patients the medical school and associated hospitals and clinics should be located in the most populous area available and should also be accessible by good transportation from a wide area. Further, it must be emphasized that the developments in medicine are now so many and oft-recurring that the facilities and faculty thought ample for medical education today call for additions and changes tomorrow, in order to prepare young physicians adequately; to do anything else than this is unfair to them and to the public. While from every point of view the personal factors in medical education are more important than anything else, nevertheless good physical facilities, or what may be called a proper work shop, are peculiarly essential to medical education, to the care of the sick, and to essential research.

MEDICAL EDUCATION IN SOUTH CAROLINA

South Carolina is a relatively small state. It is fortunate in having only one medical school, well located in the largest city of the State, with excellent traditions and background. Prior to the war between the states it was one of the leading schools of the country. With growing support from the State in recent years the Medical College in Charleston has been making substantial progress, especially in the number and quality of its whole-time teaching staff. Its long association with Roper hospital has been beneficial to both institutions and it is hoped that that association will continue. However, the Medical College has certain un-met needs which call for immediate consideration and planned action. In this connection it should be borne in mind that the standing of medical colleges is relative; that when the larger, better equipped, and better staffed schools advance such advance sets a new standard for all other schools. Ratings, therefore, are not fixed. A good rating one year, relatively speaking, without continuing development may mean a marginal rating the year following. While this situation obtains in other forms of education, one is peculiarly impressed with it in medicine, because of its rapid and continuing advancement.

A New Teaching Hospital

The Medical College of the State of South Carolina has less than one-half of the hospital beds available at this time for clinical instruction which even on a modest basis should be provided. Only one course of action is open. Unfortunately, hospitals well de-

signed and well constructed are expensive, yet they immediately serve a double purpose which must always be kept in mind, that is, they provide for the best type of medical care and they make the teaching of medicine possible. Thus every dollar spent for teaching hospitals and their maintenance serves a two-fold purpose. It was this appeal, "the education of youth and the care of the sick," which early led one of America's great philanthropists to establish a medical center which has brought healing and education to the lasting benefit of mankind for years. States can respond to the same appeal, because there is a rising tide of interest in health and all of those essentials requisite to its maintenance, on the part of every class of our population. Never before in our history has this been so evident.

The teaching hospital proposed for the medical center at Charleston, already discussed rather widely throughout the State, will not cost less than \$3,000,000. The general plans for its construction and operation are heartily endorsed. When built 325 beds are to be put in operation and the other space in the hospital used for housing nurses, internes, and residents. It should not be expected, however, that the new hospital can be used indefinitely for any other purpose than patient care. The reason for this is not far to seek. When the type of diagnostic service and treatment which the new hospital will be prepared to give is sampled by the public and by referring physicians all over the State, it is believed that it will not be too long until the new institution will be found all too small, perhaps to the amazement of many. This certainly is the history of similar activities elsewhere.

It does not seem advisable to stress further the inevitability of added clinical teaching resources which the Medical College must have in a hospital owned and operated by the school; there is no escaping it, if the Medical College is to meet current rising standards of teaching, and equally there is no escaping it from the standpoint of the service it will be prepared to give patients and referring physicians on a state-wide basis. Whether the school's enrollment is enlarged or not, and it perhaps should be increased to meet the State's need, the hospital is a *sine qua non*.

Thus far hospital discussion has been related to undergraduate teaching of medicine and to patient care. Such a hospital serves other functions, all important: greater opportunities for the education of nurses (of which there is a shortage in South Carolina), education of the hospital resident staff, and post-graduate teaching of physicians through patients referred, refresher courses, clinics, conferences, seminars, and the like. In the medical field education of the hospital interne and resident is designated graduate work. It serves as the basis for further preparation of the medical graduate either for general or specialized practice. The importance of this function is too little understood. Graduates of our medical schools of the earlier days are sometimes

unaware of the considerable responsibility which the education of the resident staff today implies, to say nothing of the lay public. This is more likely to be true of the third, fourth, and fifth years of this program. Such instruction is impossible without sufficient clinical cases and sufficient time on the part of properly qualified and interested staff members. The new hospital sought for the Medical College under the plan of operation proposed is quite as important to the education of the resident staff as it is to undergraduates. Moreover, it is notable that the location of the hospital where an interne, or resident, completes his work has much to do with his choice of a place to practice. South Carolina, already short on approved internships, cannot afford to see more of its medical graduates go to other states for hospital appointments than is absolutely necessary. When they do this their chances of being lost to the State are so considerable that the situation is difficult to control. Even when they go out of the State the authorities of the Medical College can well afford to spend time in keeping in contact with them to encourage their return for practice at home, if residents of South Carolina. It is also true that when internes are received from other states their chances of location for practice in the state where the internship, or residency, is served constitute a potential asset for medicine. From this discussion it can be seen that the new hospital has an important role to play in graduate education and that this role increases the demands upon faculty time, but is inescapable both from the standpoint of patient care within the hospital and clinic and from the standpoint of insuring more highly qualified practitioners in general medicine and in the various specialties.

Other Needs in Construction

Library. The good, small library of the Medical College is much used but poorly housed. Quarters are cramped, further expansion is limited, and noises from the street disturbing. Either the present library must be enlarged by moving out the department of pathology, or a new building must be constructed immediately across Calhoun Street from the present library, or the new hospital enlarged to accommodate it there. In either event, an expenditure of approximately \$150,000 will be required; in the case of new construction provision for further expansion should be planned from the beginning. It is suggested that the department of pathology might in the future be housed in a wing of the new hospital, constructed to connect that building with the medical laboratories across Mill Street. In that case Mill Street could be closed to vehicular traffic, except for a fire lane provided by a suitable passage through the proposed wing across Mill Street. There would be certain advantages in tying the department of pathology into the hospital and medical laboratories as suggested. If the library is enlarged within its present building the sum of \$150,000 mentioned for its construction else-

where will be required to give new housing to the department of pathology.

Completion of Medical Units. The sum of \$150,000 is needed to complete one corner of the Medical College quadrangle. Essential laboratory space must be provided. The storage shack in the center of the quadrangle according to present plans will be torn down and replaced by suitable shops and a storage building. By far the major part of maintenance and demand on shops is required by hospitals as compared with laboratories. On that account it is suggested that the present ugly and dilapidated storage shack in the quadrangle when removed not be rebuilt in the quadrangle but be assigned to space in the basement of the new hospital, with arrangements for future expansion. If this should be done, the center of Medical College quadrangle could then be converted to the purposes of a practical outdoor amphitheatre, useful for larger assemblies, including commencement. It is believed that the quadrangle is too small to justify construction of even a small building within it, with little or no chance of enlargement.

Renovation of Present Plant. The present medical school plant still needs further renovation and betterments. For this purpose the sum of \$50,000 is recommended.

Dormitory and Dining Hall. In more recent years it has been realized that medical students and internes have not been given a square deal from the standpoint of housing. The medical student is perhaps under more nervous tension, with longer hours of continued work, with fewer opportunities of relaxation and recreation, than any other student without exception. As a result too many break down physically either during student days, or soon after graduation. It is unfair to the student and just as unfair to the state which subsidizes education in part to provide less than standard living conditions with increased chances of early loss to the profession for which he seeks to qualify. It does not come within modern concepts of concern for human welfare, if one really stops to think about it, not to provide defensible standards of physical, social, moral, and cultural welfare on the part of the medical student. Here a dormitory system is almost indispensable. On that account a combination 200-capacity dormitory and dining hall, to cost \$400,000, is strongly recommended.

Land Additions and Improvements. The Medical College occupies one-half of a block in the city of Charleston. Except across Mill Street it is closely surrounded by buildings on every side, which is not atypical of early planning. Too little provision has been made for light, air, fire protection, relief from traffic noise, and aesthetic requirements. Fortunately, this situation can be altered materially. A minimum of two city blocks, bounded by Mill, Lucas, Doughty

and Ashley Streets will be needed for the new hospital, present and future dormitories, parking, which is very essential to those who spend the day at the hospital and equally essential to visitors, and other purposes which will appear in future years. It is estimated that this area can probably be secured and improved at a cost of about \$300,000. Charleston gave to the Medical College its original site. It would be a gracious thing and justified on business grounds, if Charleston again could finance the two city blocks needed today, provided the State within an agreed upon time constructs the new hospital. Such facilities bring large payrolls to communities, money spent by patients and their visitors, add to community prestige, and other advantages apart from the work of the hospital itself. A great medical center in Charleston, at least in many cities, justifies financial as well as moral support.

It is also urged that the land across Calhoun Street from the Medical College quadrangle, to the south of the land there owned by the Medical College, now owned by the city, be deeded to the Medical College for its future purposes and particularly as an assured means of keeping the area around the medical center as open as possible. In this connection it is suggested that should Roper Hospital be rebuilt in the future that it be set back from the street line to enhance appearance, reduce fire hazards, and generally improve the environment.

The one-half block partly bounded by Lucas and Doughty Streets should be acquired for future use as soon as possible. It would be a blunder of magnitude if this area were to be built up in such a way as to handicap the medical center expansion in the future, and that goes for open spaces and recreational facilities as well as for buildings. This would be an admirable site for the health center now under discussion by the public health officials in Charleston. If and when acquired it is hoped the building will be surrounded by sufficient area, properly landscaped, to give the building a suitable setting. It may also be said that the experience in other cities has well demonstrated that health centers, when located immediately adjacent to medical schools, profit far more than may at first be anticipated. By such proximity it increases the chances of consultation between the health center staff and the medical school staff, both on the laboratory and on the clinical side. But it does much more than that, it gives the medical student a ready opportunity to participate in the activities of the health center, which is important in two respects: it offers him a desirable approach to public health activities and it influences at least a few students later on to go into public health as a career. Any municipality, or county, may well go to extra expense, if that be necessary, in order to locate at least one of its health centers immediately adjacent to the medical school because of the mutual advantages assured. This advantage can well be demonstrated by visits to medical centers where such

arrangements exist. There are notable cases where the health center was located a half a dozen blocks or more from the medical center quite to its handicap, as can be ascertained by inquiry.

Funds for Support of Operations

South Carolina currently has appropriated \$286,000 for the operation of its medical school, this being supplemented by properly charged student fees. For the year 1946-47 the College has requested an appropriation of \$314,000. Based on the size of its operations and the need of strengthening its program this request is fully justified. In frankness it can be said that an appropriation of \$350,000 could not be regarded as extravagant.

Continuation Education

In addition to the education of undergraduates, internes, and residents in medicine and related subjects, every medical school has responsibility for organizing its resources to make it practicable at minimum expense for busy practitioners of medicine to keep themselves abreast of developments. This responsibility has been brought into sharper focus by two recent events: our young men and women have gone into the armed services in large numbers with too brief periods of previous hospital experience and many were engaged in types of medical service which they do not expect to follow in civilian life; the practitioner who remained at home to meet civilian requirements in medical service has in most instances been too busy to attend medical meetings, postgraduate clinics, refresher courses, and so on, and has even been too busy to do routine professional reading. To both of these classes of physicians our medical schools should offer those forms of instruction and clinical opportunities which will best meet their immediate requirements. This presents a complicated problem. Its solution in Charleston will depend upon how many individuals can be added to the interne and resident staff and what resources in money and personnel can otherwise be brought to bear upon it. In the future the new hospital and other resources recommended will make a continuing contribution to postgraduate service. Immediately there must be funds to sustain the program. Their provision further justifies the increased support for operations mentioned above.

Administrative Organization

The Medical College has an extremely simple administrative organization. It may be said that it has made out remarkably well with it. However, it is suggested that when an organization reaches the size and complexity of the present Medical College, and what it hopes to be in the near future, it is highly probable that the institution should be headed by a president, who could give virtually whole time to his work. He could pursue many undertakings

of value to the institution and under the best possible circumstances for which there is no time or opportunity under the present organization. Many of the citizens of South Carolina, corporations as well, should if possible be led to see the opportunities of investing money in medical research, in patient care, in scholarships and loan funds for students, in buildings, equipment, and other items, either while living or through provision in wills. Things medical and the care of the sick make first appeal to those who can share with others even though the sums be small. This is not the place to outline in detail the responsibilities which a president of the Medical College might undertake, quite out of proportion in importance to the extra cost entailed. It should be recorded that this suggestion came from no one in Charleston. It originated from study of the situation there as compared to similar situations. In a few instances where medical schools are located on the university campus, there is a vice-president for medical affairs, because of the importance, and to repeat, because of the complexities of the factors involved in medical education, in hospital operations, and in public relations.

If the office of president were created the deanship and other administrative officers would of course be continued. When the new hospital is constructed an administrator for that activity will be necessary.

Outlying Hospitals and the Medical Center

The layman must realize that medical service adequate in quantity, quality, and distribution over the State depends upon other factors besides the activities of a well developed medical center, such as is proposed for Charleston. One of these has already been mentioned, the internship; internes do strongly tend to locate in the state where the internship, or residency, is served. The other factor on which there is growing emphasis is the availability of well distributed hospitals of quality over the state. The modern trained physician can no longer practice his profession at the crossroads. To him the hospital with its diagnostic resources and therapeutic facilities is just as indispensable as the schoolhouse is to the teacher and the laboratory to the scientist. Furthermore, he should not be expected to provide his own workshop any more than the teacher or scientist. General hospitals are local responsibilities just as much as schools and because of their importance are being so recognized apace. It is quite as easy to make the same mistakes in their establishment as were earlier made in the development of school systems. Local health centers may be small units to house public health functions, including administration, arrangements for clinics, and a small number of hospital beds to meet acute emergencies, but hospitals as such must be large enough to justify the fullest possible range of diagnostic and therapeutic procedures with the best possible professional care. Here the complications are so many and the expense

so great that every community should not expect to maintain a hospital.

This study does not justify complete discussion of hospital location, organization, administration, cost of construction and operation, and other important points. It is advisable, however, to point to a new trend, that hospitals in the future will likely be organized, on a voluntary basis to be sure, into systems; that the smaller hospitals will look to the larger hospitals and the larger hospitals to the medical center of the State for a variety of services not now generally available. To be specific, the medical center in Charleston should look forward to providing on an itinerant basis consulting and educational services, when requested, to certain larger hospitals of the State, and even the smaller ones if near enough; the smaller hospitals to look to the larger hospitals thus served by the medical center for similar services. This does not mean the referral of cases from one type of institution to the other so much as it means extending on an itinerant basis both consultation and teaching to whatever hospital seeks it. By this means consulting service in all fields, not alone in x-ray, pathology, clinical pathology, et cetera, but also in the clinical branches will be available to outlying hospitals. Such consultative service should have a fixed routine, so that a certain doctor, for example, would appear at a given hospital by arrangement at a certain time where he would meet his professional colleagues in the laboratory, or make rounds with them on patients. Such a program would be highly stimulating and likewise contribute to better medical care.

Postgraduate courses, clinics, symposia, et cetera, can be set up in outlying hospitals if desired in direct relation to the patients of those attending quite as well as in Charleston and in some respects to greater teaching advantages, and certainly to less expense to those for whom arranged. In such teaching (off-campus continuation education) there is a place for experts brought from without the state, to add variety and expertness. It must also be pointed out that this type of activity can be undertaken by hospital centers outside of the Medical College, although the continued co-operation of that institution is highly important. It is believed that the advantages of some such program as this are so great both to practitioners of medicine and to the health of the public that the State can well afford to appropriate money for it. If an initial sum of \$10,000 to \$15,000 to make a demonstration were appropriated, the results are bound to be good. One of the deep fears of a young practitioner is that he will suffer from isolation. This program is one of the cures for that and when young men in medical school and internships see it in operation it will inevitably draw them to the communities where the level of practice has been raised and sustained by good consultative and educational procedures. Finally, it must be restated that if South Carolina is to have the medical service required in

these times, it must consider other factors besides building a medical center in Charleston, although that is of first importance; otherwise, the State will suffer from turning out high class practitioners without local practice facilities, and without professional contacts by which men grow in strength and usefulness.

Prepayment for Medical Service

The movement in South Carolina now under way to make it easier to secure hospital care and perhaps payment for professional services while in the hospital is to be encouraged both publicly and privately. The Blue Cross plan by which an individual makes monthly payments to guarantee for him, and for his family if he desires it, hospital service under a contract now has some 17,000,000 members in the United States. More recently a supplementary contract, known as the Blue Shield plan, adds the cost of medical, surgical, and other professional fees while a hospital patient. Where these plans have been longest in operation it is found that many who otherwise made no financial arrangements for hospital care and service now do so, thus saving private donors, local communities and the state large sums from private donors, or tax funds, which once went to free service or part-pay service, for those who could not pay because of the absence of an organized plan of doing it. It can be expected in the future that increasing numbers of individuals will insure themselves against the financial difficulties of catastrophic illness by means of prepayment, likely by plans which have thus far not been devised. The State can well afford to encourage such movements from the standpoint of self-interest and from the standpoint of the public good.

The Negro in Medicine

South Carolina has a large Negro population with perhaps less than fifty-five Negro physicians. Experience has demonstrated that there is a place for the Negro in medicine; that he can make a living under favorable circumstances; and that he can serve his people usefully. It is neither too difficult nor too expensive to give him an opportunity to qualify for medical practice. Several southern states have already adopted this plan, varying somewhat in details, and other states are considering doing so. Taking Virginia as an example, there the State appropriates funds to the board of its State College for Negroes, and that board is empowered by law to do two essential things: First, to contact with Meharry Medical College, Nashville, Tennessee, a high grade institution for Negro students, to receive its acceptable Virginia students in medicine for which payment is made to that institution in the amount of \$500.00 per year per student as a subsidy to cover the difference between what the institution's endowment and tuition fees provide and the cost of instruction; and, second, to pay the student's tuition in whole or in part as a means of offsetting the difference in cost of attending

a school away from home and what it would cost in the home state. This program, administered by the president of the State College for Negroes, makes it possible for Virginia to secure a superior quality of medical education for its Negro youth. The state is also lending support to the only medical school in the South for Negroes, a school which is needed and which should be continued by the cooperation of other states. This program is simple, easy to administer, and has every advantage over possible attempts to set up third or fourth-rate medical schools in the South for Negroes. In any such plan it is advisable to limit the number of students for which the state will accept responsibility annually. It is further to be expected that with rising costs of medical education the subsidy at Meharry may have to be increased in the future. Medical education on such an interstate basis is not limited to the requirements of the Negro race. The first undertaking on this basis was established for white students.

Ratio of Physicians to Population in South Carolina

Dr. A. M. Lassek, professor of anatomy, Medical College of the State of South Carolina, has during the past several years published a series of studies in the Journal of the South Carolina Medical Association on the State's standing in physicians, their distribution, and number of hospital beds in proportion to population including estimated needs. The data here submitted are taken from Doctor Lassek's significant contributions to this subject.

In 1942 the ratio of physicians in actual practice in South Carolina to the population was one to 1,416, one of the lowest in the United States, as compared to an acceptable ratio of one to 1,000. The census report of 1940 rated South Carolina forty-sixth in this regard, only one state being lower.

South Carolina has had an unfavorable ratio of physicians to population at least since 1906. Its medical school at Charleston has contributed a gradually increasing number of physicians, who have remained in the State, the figure being greatest in 1942 when the last study was completed. Then it was recorded that 738, or sixty-seven per cent, of the living graduates of the Medical College were practicing within the State. At that time a considerable number of other graduates were taking internships and residencies in other states with a chance that a fair number of these would return to South Carolina to take up practice there. It is believed that the Medical College can be rated high on the basis of its graduates practicing in the home state when all factors are taken into consideration.

In common with other states, physicians have been moving to urban centers in South Carolina, or have not been replaced in the rural sections, during the past one-third of a century and longer; this a typical national trend. Meanwhile, the crossroads store, the

mill, and other enterprises have likewise tended to disappear, or have changed in functions. Perfectly good explanations can be found for this situation. None the less when it is realized that ten of the largest cities of South Carolina have more than one-half of all of the doctors of the State, it is a situation to be reckoned with. On the other hand, it is easy to understand how ten of the largest cities of South Carolina would have more than four-fifths of the State's medical specialists; their work cannot well be done in the smaller communities.

As stated before, modern medical practice assumes the availability of acceptable facilities for such practice; it also assumes the presence of potential patients in sufficient numbers economically prepared to pay for services; assumes a reasonable income somewhat in line with the long and expensive years in preparation for practice; assumes, too, preferably professional association with others in general practice, or in the specialties, in order to remove the serious handicap of professional isolation; and assumes an environment suitable for living in reasonable comfort with good schools, churches, and other social and cultural advantages which will permit rearing a family under at least average American standards. Such factors as these are seldom available at the crossroads; they are to be found in towns and cities.

The local hospital with its diagnostic and treatment facilities is coming to be the first requisite for the modern practice of medicine. According to Doctor Lassek, South Carolina has a deficit of 4,300 general hospital beds; only one county meets the standard in beds of the Federal Government, which is 4.5 general hospital beds per 1,000 population. Over 1,000,000 persons in the State according to this figure were not adequately supplied with general hospital beds in 1942. This is not unexpected, certainly in part, in a State so largely rural as South Carolina. Nevertheless, it is a challenge to State planning and effort. It is probable that there will be Federal funds available before long with which states will be enabled to study intensively their hospital needs, as a basis for formulating plans to meet their needs; funds for hospital construction may also be available. It is recommended that steps now be taken to permit prompt action when and if these funds become available.

Sufficient has been said here, it is thought, to indicate that South Carolina may well congratulate itself upon its record in holding the graduates of its medical school; to show the place of the local hospital, economic conditions, and other factors in attracting physicians for practice, and to suggest what further must be done in attracting and holding medical practitioners, such as hospitals approved for the training of internes and residents. South Carolina particularly needs more of these; the greatest immediate advance here can be made through the hospital recommended for the Medical College at Charleston.

Should Medical School Enrollment Be Increased?

As far as service to the State is concerned, there is little point in increasing medical school enrollment until other objectives are reached. The first of these is the clinic-hospital for the Medical College, other physical betterments and funds for operations there; other desirable objectives are mentioned in the preceding sections. There are respects in which the Medical College staff can assist local hospitals of sufficient size to take the necessary steps to secure approval for internships. The construction of hospitals on a statewide, planned basis; their voluntary coordination and cooperation to secure for local hospitals consultative and educational services as mentioned above; and still other procedures which statewide studies will uncover should follow.

It is highly probable that within a few years an entering class of seventy-five or eighty at the Medical College in Charleston will be justified, this to be undertaken when the other larger related factors are duly met.

Student Loans for Rural Practice

A number of states are now experimenting with scholarships, or student loans, provided on the condition that the recipient of such help practice for a designated period in rural areas where physicians are sorely needed but to which they are not likely to be attracted for various reasons. The outcome of this endeavor has not been fully appraised because it is too recent. South Carolina might appropriately wish to join in this yet experimental procedure of securing medical service for some of its more restricted areas.

In providing student help on condition that service be rendered to the State, it is recommended that financial aid be put on a loan rather than a scholarship basis, the loans to be paid off in proportion as the agreement for service is fulfilled. When the emphasis is upon loans rather than scholarships the sense of obligation is heightened.

One method of working out the foregoing suggestion might provide that annual loans be made to a restricted number of students, say four the first year, selected by the Medical College authorities from among applicants reared in country communities, the loans to be \$800 a year, evidenced by two notes of \$400 each without interest, each note to be paid off by a year's practice in a country community, selected by the dean of the Medical College and the State Commissioner of Health; the recipient of such a loan should have the right to repay it, either in whole or part, with interest in lieu of repayment in service, if he so elects. Such an arrangement presupposes an appropriate contract between the student and the Medical College, the form to be approved by counsel. It is also expected that notes will be properly endorsed; in some instances insurance policies to pro-

teet the State for the amount of the loan have also been required. For the student receiving such a loan for a full course of four years, the cost to the State would be \$3,200 and the service obligation by the individual eight years. Educating four students a year in each of the four years of the medical course would cost when the plan was fully in operation \$12,800 annually. It is suggested that not more than 3,200 to be made available the first year.

Education on a Regional Basis

With improved transportation and a growing appreciation of the advantages of cooperation, and with the realization that few states have sufficient funds to undertake high quality technical, professional, and graduate education in every field the need of planning for certain types of education on a regional basis has come to be a vital issue; even within the same state it is recognized that every institution cannot attempt to develop all of its departments equal to similar departments in other institutions. Hence, institutions must undertake what they can do best, leaving to others the emphasis which they can best give.

Regional education applied to South Carolina means that there are some types of education for which it may well look to other states, saving unnecessary and very expensive duplication by cooperating with those states. It is not within the province of this report to discuss phases of graduate education which may have regional implications. However, it is deemed highly desirable to suggest here that South Carolina subsidize qualified Negro candidates for medical education at the Meharry Medical College, Nashville, Tennessee, both as to tuition and the cost to that institution for medical education not covered by tuition and endowment; also to propose that public health nursing and dental education be secured regionally, as suggested below. These suggestions are not intended to be limiting; they are immediate and typical.

It has been found that a good method of supporting regional education is to appropriate funds to the institution at which that type of education if given might be set up. For example, in the absence of medical and dental schools at the State Agricultural and Mechanical College, at Orangeburg, appropriation should be made to the board of that institution to educate Negro medical and dental students at Meharry Medical College. Again, in the absence of schools of dentistry and public health nursing at Charleston funds should be appropriated to the Medical College there for that type of work elsewhere, and so on. The authorities of these institutions can readily ascertain from other states now securing some form of regional education as to how best proceed in this type of work whenever it is undertaken.

Recommendations with Respect to Medical Education

1. The urgently needed clinic-hospital should be

made available for the Medical College just as soon as conditions are favorable for construction. It is essential for undergraduate instruction, for the education of internes and residents, for the instruction of nurses in the basic course and in preparation of head nurses, supervisors, and nurses in special fields, such as psychiatry, pediatrics, and so on; for postgraduate education, refresher courses, clinics, and other arrangements to keep practicing physicians up to date; and for referral of problem cases from physicians over the entire State on the basis projected by the medical school authorities.

2. At least \$3,000,000 should be made available for the new hospital construction, from tax funds or jointly from the State and Federal Government should the latter offer to cooperate.

3. These further sums should be made available for capital outlays:

Library -----	\$150,000
Completion of Present Units -----	150,000
Renovation of Present Plant -----	50,000
Dormitory and Dining Hall, 200 Capacity -----	400,000
Land Additions and Improvements (if not contributed by Charleston) ---	300,000

4. Appropriation for the operation of the Medical College should be increased from \$286,000, current, to \$314,000 for the next fiscal year.

5. Postgraduate or continuation education should be undertaken by the Medical College in a more ambitious way when the new hospital is ready for operation, both on and off the campus, and \$10,000 should be appropriated to start the work.

6. The board of the Medical College should consider strengthening its administrative organization by creating the office of president.

7. When the new teaching clinic-hospital begins to operate in Charleston its staff should seek to extend the resources of the institution both in the medical sciences and in the clinical fields to other hospitals in the State which may profit by them on a consultative and educational basis, assuming that such hospitals volunteer to receive this assistance, and assuming also that outlying hospitals will seek in time organization to promote cooperation and mutual assistance.

A sum of \$3,200 should be appropriated the first year for the purpose of making loans to four medical students, especially selected by the Medical College with the understanding and agreement that for each year such a loan is made its recipient repay the principal without interest by practicing in a designated rural area for a two-year period, or otherwise repay the loan, in whole or in part, with interest in lieu of practice.

8. Pre-payment planning for hospitalization and professional services within hospitals should be promoted in every possible way in order to give a maximum number of individuals and families the best

possible chance to prepare for the payment of medical care costs in the most efficient manner yet proposed.

9. The State, in view of its large Negro population, should consider accepting reasonable financial responsibility for providing funds both for tuition and subsidy of other educational costs at the Meharry Medical College, Nashville, Tennessee, for medicine and dentistry on a contract basis, appropriating funds for the purpose to the board of the State Agricultural and Mechanical College at Orangeburg.

10. Immediate steps should be taken to prepare for the study of the State's hospital needs and of how to meet them in anticipation of Federal funds for this purpose.

11. The possibilities of regional education for white students to secure public health nurses, dentists, and other highly specialized personnel who can be prepared more economically and effectively on this basis than by setting up courses at this time for their instruction within the State should be followed, appropriating necessary funds to the Medical College.

13. In viewing all of the foregoing problems it should be borne in mind that there is an acute shortage of physicians and other health-service personnel in South Carolina; that the pattern of medical practice is changing, requiring the availability of local diagnostic and therapeutic procedures as found in good general hospitals of ample size and resources; that the problems of rural states are more difficult to solve than others; that the standards of medical education and medical practice are advancing rapidly; and that the public generally is far more interested in up-to-date health services than ever before and can be counted upon to back soundly planned endeavors in this direction if given an opportunity to do so.

Exchange Department

(Each month there come to the editorial offices of this Journal more than two score state or sectional medical journals published in the various parts of this nation. Many of these journals contain articles and editorials which would be of real interest to the members of our Association.

As space permits, we will publish selected articles or editorials or comments or abstracts of these in this department of our Journal.)

FROM THE NEBRASKA STATE MEDICAL JOURNAL—FEBRUARY, 1946

(The author—Dr. Jahr is a pediatrician, and is also editor of the Nebraska State Medical Journal.)

EMERGENCIES OF THE NEONATAL PERIOD

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It is now accepted that the care of the infant begins with the earliest stages of pregnancy. If we

carry the point to logical length, it becomes self-evident that the fate of the fetus is wholly dependent upon the ability of its mother to supply the building materials from which the organism is to develop. Even if we accept the idea in full that the fetus draws all he can on the maternal resources for his own utilization, it still remains true that the care of the pregnant woman is one of the most important phases of infant hygiene.

One of the major considerations from the standpoint of the infant, is the preparation of the mother for delivery. Most young mothers especially, are now aware of the importance of prenatal supervision. The doctor for his part has the opportunity to gain a comprehensive idea as to the general state of health of his patient, the pelvic measurements, and by examination, determine with a fair degree of accuracy existing anomalies of the fetal position, and plan his conduct of labor accordingly. In cases where difficulties from maternal or fetal causes are predictable, labor should be elective as to time and type.

The analgesic or anesthetic should be chosen with the view to maximum safety for both the mother and the infant. It has been said that the safest anesthetic is the one with which the surgeon is most familiar. This may be true for surgery in general, or where the safety of the patient alone is concerned. In obstetrics, the safest anesthetic is the one which is least harmful to the mother and least damaging to the infant. It must be constantly borne in mind that the fetus even under normal conditions, is under a constant state of oxygen deprivation. Under adverse conditions his status may become very precarious.

Many workers in the field of embryology believe that respiration goes on in utero, though not all of them agree that it is carried to the extent of gaseous exchange in the fetal lungs. That many infants react unfavorably to analgesics and anesthetics given the mother is evident from the numbers of infants who are born asphyxiated, and who subsequently show signs of cerebral injury. Caution in the choice of an anesthetic is particularly urgent in cases of premature deliveries. According to some obstetricians morphine, scopolamine or the barbiturates should not be employed in such deliveries.

Asphyxia

All too frequently, even a normal delivery will yield an infant who seems reluctant to take his first breath. He appears well formed, not too cyanotic, with a steady, rapid pulse of good volume. The apnoea may last for several minutes, following which the cyanosis will deepen and the child will issue his first cry. Respiration will go on uninterrupted. The delay in such cases is probably due to the fact that the infant was born with blood relatively rich in oxygen. He did not breathe until enough CO₂ accumulated to stimulate the respiratory center.

The question is sometimes asked: "How long can the brain of the newborn infant be deprived of

oxygen without suffering permanent damage?" The answer cannot be supplied in definite terms. Some believe a maximum of three minutes, others maintain that even less than one minute may produce an irreversible reaction. Actually we have all seen infants who had difficulty establishing their respiration for longer periods than the maximum here quoted, and who nevertheless escaped the results usually associated with cerebral damage of anoxic origin. Whether this impunity is the result of brain tissue resistance in the individual infant or whether it is the response to a conditioning process over months of life under low oxygen levels or a combination of these and other as yet unknown factors, may be anyone's guess. It is, however, foolish to tempt Providence. In the case of the baby who has difficulty in establishing his respiratory function following delivery, and under the logical assumption that oxygen want is a dangerous phenomenon, the gas should be supplied by whatever means may be at hand.

Asphyxia is brought about by a reduction of oxygen in the circulating blood. This reduction may be of peripheral or of central origin. In the peripheral type there is an interference with the entrance of oxygen into the circulation. This may occur in utero from such conditions as premature separation of the placenta, the cord around the neck of the fetus, or a severe anemia of the mother. At the time of birth it may result from strangulation, or aspiration of amniotic fluid or other foreign material. The intrinsic or central variety is due to actual interference with the functions of the infant's respiratory center. Cerebral hemorrhage or edema, toxemia, or shock, resulting from the sedative or anesthetic administered to the mother prior to delivery. According to Cole¹, "every additional dose of any sedative increases the incidence of asphyxia in direct proportion to the amount given." Morphine and the barbiturates act directly as depressants of the respiratory center. Others produce their damaging effects indirectly by prolonging labor or by affecting the brain tissue.

The care of the asphyxiated infant should be evaluated on the basis of common sense rather than on empiricism. For example, not infrequently both extrinsic and intrinsic factors may operate. Thus it is conceivable that an infant partially asphyxiated from the umbilical cord around its neck may in addition suffer from an overdose of morphine and barbiturate given his mother prior to her reaching the delivery room. In similar manner one may encounter a toxic baby delivered of a toxemic mother, with a trachea plugged by mucus and amniotic fluid.

Whatever the cause of asphyxia, it should be treated as an emergency requiring gentleness, calmness, and intelligence. The first consideration is to clear the upper air passages in order to allow access of oxygen. With the head down, the nose and mouth are wiped with soft gauze, and the trachea

milks gently of aspirated fluid. Oxygen may then be given through a glass funnel if more elaborate apparatus is not available. The mucus must be aspirated from time to time, either by repeated milking of the trachea or by a syringe, or both. Oxygen should be supplied until the skin assumes a normal color. The infant may then be allowed to breathe air, but must be constantly watched. On reappearance of cyanosis, oxygen should be readministered. Needless to say, at all times the infant should be kept warm. In most instances where the asphyxia is not due to cerebral hemorrhage the simple procedure outlined above will establish breathing.

Comparatively few pediatricians have faith in drugs as a means of resuscitation. They are being used, however, and indeed should be used when other means fail. Tow² believes that the practice of placing the child head down following resuscitation is based more on habit than on physiologic principle. He does not believe that this position promotes escape of aspirated fluid through gravity, because the cilia in the upper air passages interfere with the process. He recommends the Fowler position, on the theory that the latter position makes breathing easier. It is well known that patients with pneumonia or cardiac decompensation prefer the Fowler position because they feel more comfortable in the sitting posture. The Fowler position, he believes, is especially important in the case of the premature infant, because of the ever present possibility of cerebral hemorrhage. It has been shown that the spinal fluid pressure is less in this position than with the head lower than the hips.

Cerebral Edema

Cerebral edema often presents a difficult problem in diagnosis. The symptoms are similar to those of intracranial hemorrhage. The most important and most prevalent manifestations are convulsions. The frequency of the convulsions depends largely on the extent of the intracranial pressure and on relief following treatment. The edema is a result of positive and negative pressure on the descending head by the forces of labor or of toxins of maternal origin. Unlike cerebral hemorrhage from intracranial injury and often localized and accompanied by local twitching, the cerebral edema involves the brain as a whole and the symptoms produced are those of generalized and marked irritability of the brain.

Spinal puncture may reveal a few red cells in the cerebrospinal fluid. Cerebral edema may be differentiated from intracranial hemorrhage by the fact that in the latter condition the blood occurs in much greater amounts than in the cerebral edema, where the blood cells are probably the result of diapedesis rather than direct seepage from a broken vessel.

The treatment of cerebral edema consists of control

of convulsions which may be achieved through the use of sedatives, intramuscular injections of 1 cc. of a saturated solution of magnesium sulfate, spinal fluid taps to relieve the pressure and the intravenous use of 50 per cent sucrose.

The prognosis generally is favorable, provided that the convulsions are controlled prior to the time where irreversible changes in brain tissue take place. In the majority of cases, the results are good. Following the reduction of pressure, the convulsions cease and the infant makes an uneventful recovery.

Intracranial Hemorrhage

Intracranial hemorrhage may occur following birth under any variety of conditions. While most cases of hemorrhage result from difficult deliveries, any infant, regardless of type of labor he has gone through, in the presence of symptoms pointing to cerebral irritation, should be suspected of suffering from intracranial hemorrhage. Clinically the condition may be divided into groups based on the intensity of the damage. A mild hemorrhage with minute capillary bleeding may produce nothing more than a restlessness and a refusal to nurse. Twitchings of muscles may or may not be present. These infants at times offer no serious problem, particularly if the bleeding ceases before a clot has been formed. The treatment of this type of hemorrhage consists of keeping the child as quiet as possible by the administration of adequate doses of sedatives. In the majority of cases, that is all that is necessary.

The moderate type is a serious problem. Depending upon the location of the bleeding, symptoms may range from local twitchings to violent, generalized convulsions. Where in the milder type the symptoms may not become apparent until several hours or even days after birth, in this variety the infant as a rule shows symptoms at birth or immediately thereafter. Asphyxia is almost the rule. Following resuscitation, the infant usually goes into a stupor accompanied by difficulty in respiration. The administration of oxygen may clear the cyanosis for a short period when the infant, following a series of muscle spasms, again stops breathing. This process may go on for several hours or days, following which convulsions cease and the infant may show no signs of disturbance until signs of spastic paraplegia with or without mental deficiency become apparent.

In the treatment of this type of hemorrhage the first effort should be directed to checking of hemorrhage. The former use of blood intramuscularly has been replaced by Vitamin K in some form. Sedatives must be used in adequate doses to secure rest. Spinal taps are indicated where the pressure is markedly increased. One point should be emphasized: the damage to the brain tissue in these cases may be due not only to the hemorrhage itself but also to the lactic acid resulting from severe muscle contractions and to the anoxia suffered during

the periods of apnoea. The importance of oxygen administration in these cases therefore becomes obvious.

The massive hemorrhage offers less of a problem in the majority of cases than does the moderate type because many of the infants who suffer from profuse intracranial hemorrhage do not survive more than a few hours. Frequently they do not recover from the asphyxia during or following labor. Those who do survive are as a general rule spastic, and almost invariably suffer from mental deficiency.

In connection with the prognosis, it is well to remember that not infrequently an infant presents all the symptoms of a severe massive hemorrhage which looks hopeless, yet the infant may not only survive but may show little, if any, evidence of intracranial damage. The following case will illustrate:

Baby C. born in Lutheran Hospital following a very long and difficult labor. Asphyxia was pronounced. Following resuscitation, the baby slumped into unconsciousness and stopped breathing. Oxygen was administered and respirations returned but remained irregular. One hour after delivery there was a severe generalized convulsion. Respiration again stopped but returned with the administration of oxygen. There were repeated, generalized convulsions for five days. At the end of the fifth day, the child began to improve and to take its feedings. Progress was uneventful and he was dismissed from the hospital on the 14th day. The spinal fluid done on the first day was bloody and continued so until the tenth day. This child is now two years old. He has made normal progress in his physical and mental development.

The explanation in these severe, massive hemorrhages where the baby escapes permanent cerebral damage is that the hemorrhage is mainly meningeal and that the brain itself was not involved, or that the site which may have been involved is one of the silent areas.

Atelectasis

The frequency with which this condition appears is difficult to determine, since in most instances the collapse of the lungs includes only a small surface and the infant escapes many of the symptoms referable to the respiratory function. In this condition, too, the problem of diagnosis at times becomes difficult. In some cases, the difference between marked atelectasis and intracranial damage which affects the respiratory center, is difficult to determine.

Generally the infant is born asphyxiated, resuscitation is prolonged, and, following respiratory effort and a weak cry, the infant again falls into a state of asphyxiation with little or no effort at respiratory movements. The grunting respiration following resuscitation persists at times for several hours. The

infant remains stuporous and no breath sounds or very weak sounds, may be heard on auscultation. In cases where atelectasis involves a large part of one or both lungs, very few, or no breath sounds may be heard. Not infrequently if the child survives the initial stage of asphyxia, twitching and convulsions may be seen, due to anoxemia.

Atelectasis should be considered an emergency and treatment instituted on that principle: 1—Keep the child warm; 2—Artificial respiration, either manually or through a respirator, if one is available; 3—Frequent administration of oxygen. The last phase of the treatment can not be overemphasized. If one takes into account the mechanism of respiration in the newborn, one can not minimize the importance of oxygen as a means not only of saving the life of the infant but also of preventing irreversible cerebral changes due to anoxemia.

It is well known that when the infant is born the lungs are in partial collapse. The first cry sends the volume of air downward through the trachea, the bronchi, to the smaller branches of the bronchial tree. With increased breathing air ultimately fills the entire lung, including the small capillaries. An infant who does not breathe spontaneously but shows evidence of attempted breathing, if encouraged, by the administration of carbon dioxide or artificial respiration, will ultimately take in enough air to relieve the collapse. However, it is important to provide a richly supplied oxygen atmosphere which during the time of shallow, irregular respiration will maintain a sufficient oxygen volume to prevent anoxemia, because even a temporary oxygen deprivation may produce permanent cerebral damage.

By and large, and particularly where the atelectasis does not involve a large surface of the lungs, or where oxygen is supplied during the period of contingency, these infants make a good recovery.

Diarrhea of the Newborn

While the conditions thus far enumerated are to be found at birth or immediately after birth, diarrhea of the newborn usually manifests itself almost at any time during the period in which the infant is struggling for survival. From the etiologic viewpoint, the diarrheas of the newborn may be divided into two distinct groups: the infectious and the biochemical.

The symptoms in both these groups do not vary much; the child becomes ill very suddenly with high fever and prostration. The stools become frequent and dehydration follows rapidly. The distinction between the two types may be made only through the isolation of the sheiga bacillus in the infectious type. In this type, the infant usually acquires the diarrhea as a result of a toxemia produced by the organisms. As a general rule, the infection is brought into the nursery through the personnel. The organisms may gain entrance through the feeding or by almost any means which may or may not be easy to trace.

In the case of infants who acquire diarrhea without infection, the story is a familiar one. It is found usually in the summer months during hot and sultry weath. Most of us are under the impression that when a child loses water and becomes thirsty, it will make its thirst known by crying or fussing. While that is true as a general rule, there are infants, especially those who are below par to begin with, in whom a great loss of fluid will produce marked weakness and somnolence which will render them unable to manifest the usual means which bring attention.

The sequence of events is about as follows: profuse sweating, dehydration which brings about frequency in stools. These in turn increase the dehydration with the result that toxemia sets in, respiration becomes irregular with accompanying anoxemia, acidosis, and often death. The condition is an emergency which calls for prompt and effective treatment. The treatment consists largely of replacing the water loss and combatting of toxemia and acidosis.

In the case of infectious diarrhea, the prognosis is unfavorable because of the toxic elements which circulate in the blood stream. Epidemics of this type of diarrhea are recorded from time to time, with deaths ranging from 10 to 80 per cent of the nursery population when attacked. Fortunately, the condition is not as treacherous as figures indicate, provided that the nursery staff is alert and uses procedures now accepted as preventable and therapeutic.

Common sense calls for immediate separation and isolation of an infant with diarrhea, regardless of origin. Any infant who shows a frequent watery stool calls for thorough investigation, including a bacteriologic examination of the stool.

Treatment consists of replacing the lost fluid by means of blood or plasma transfusions and/or administration of saline or Hartman solution, these to be repeated as the condition of the infant indicates.

In giving these fluids, it is necessary to take into account the size of the infant and to remember that such an infant can tolerate only a certain amount of fluid. As a general rule, it is better to give small transfusions frequently than it is to give a large transfusion at one time. Where the dehydration is not too grave, 50 to 100 cc of Hartman solution intravenously or subcutaneously once or twice a day is usually enough to prevent a marked decline. If blood is given, 100 to 150 cc at one time should be injected. The use of sulfanamides is doubtful in these cases, and penicillin is at the present time not considered specific. However both or either should be tried.

Feedings should be given by mouth only if the child does not vomit. Where vomiting exists, food will only add to the irritation and to dechlorinization. In cases where an infant has diarrhea without infection, preventive measures consist of the appreciation

that during hot weather infants need water frequently. Whether it is accepted or not, during hot days water should be given to every infant between feedings. No one knows when a child is thirsty and not all infants cry when they are thirsty. As was observed earlier, some may be too weak to cry.

FROM THE PENNSYLVANIA MEDICAL JOURNAL

(The following article was written at the request of the Committee on Scientific Work, Section on Obstetrics and Gynecology, The Medical Society of the State of Pennsylvania.)

PENICILLIN IN OBSTETRICS

HOWARD A. POWER, M.D. and

CHARLES A. CRAVOTTA, M.D.

Pittsburg, Pa.

In our preliminary survey read before the Pittsburgh Obstetrical and Gynecological Society in April, 1945, and accepted for publication by the *American Journal of Obstetrics and Gynecology* (not published to date) we outlined the indications, contraindications, and limitations of sulfonamide therapy and compared these factors with those involved in penicillin therapy. We furthermore noted the fact that the dosages used were empiric and perhaps could be somewhat reduced by one of the various methods for prolonging the action of this latter drug.

For this summation, we refer you to the original article which should appear in the *American Journal of Obstetrics and Gynecology*, January, 1946 issue.

Acute Mastitis.—Twenty-five cases of acute mastitis are reported. The minimum total dosage in this series was 100,000 units, the maximum 900,000, and was in direct proportion to the apparent virulence of the organism and the degree of breast involvement. The duration of therapy was from fifteen to seventy-two hours. There was no failure in this series. As previously reported, the erythema and cellulitis had diminished 50 per cent within the first twenty-four hours of therapy, and had usually disappeared entirely in forty-eight hours.

Cesarean Section.—The use of penicillin following cesarean section has been divided into its prophylactic use and its use as a curative agent when infection was definitely established. Prophylactically the drug was administered only to patients who were potentially or actually infected at the time of operation. As a curative agent the administration was delayed following operation until definite evidence of infection was present. Penicillin was used prophylactically in thirteen instances and was used thirteen times for active treatment. When used prophylactically the total dosage varied between 100,000 and 900,000 units. When given for active treatment the total dosage varied between 300,000 and 1,575,000 units.

As previously reported, when given to potentially infected patients, prophylactically, the hospital stay

was of average duration, namely, twelve to fourteen days. When the administration of penicillin was withheld until definite evidence of infection was present the stay was prolonged, the minimum duration being fourteen days and the longest forty-two days. There was no mortality in either series.

Endometritis.—Under the heading of endometritis our original series of 11 cases has been increased to twenty. These patients were delivered vaginally and exhibited pyrexia, profuse foul lochia, uterine tenderness, and systemic toxicity. The uterine cultures contained hemolytic and nonhemolytic streptococci and *Staphylococcus albus*. The total dosage of penicillin ranged from 100,000 to 1,700,000 units. The febrile reaction following penicillin therapy lasted from twenty-four to forty-eight hours in the majority of instances and in two cases it required eight and twelve days for the disappearance of pyrexia. The hospital stay in the majority of instances was from ten to sixteen days and was prolonged to twenty-six and twenty-nine days in two instances. There was no maternal mortality.

Septic Abortion.—Our initial series of five cases has been expanded to twenty-three. In this series the minimum total dosage of penicillin was 175,000 units and the maximum dosage was 1,610,000 units. The same organisms were present as were found in the endometritis series. The shortest febrile reaction was twenty-four hours; the longest one hundred and sixty-eight hours. The hospital stay ranged from six to thirty days. The prolonged hospitalization was due to severe secondary anemia rather than to the persistence of infection. Seven of these patients had hemoglobin readings of 30 per cent or less. In septic abortion with severe secondary anemia the administration of penicillin is apparently doubly valuable because of lack of influence on the red blood cell and hemoglobin levels. There was no maternal mortality.

Gonorrheal Infection.—Two cases of proven gonorrheal infection have been added to the original three cases reported. All were apparently cured. In one of these patients a positive smear was obtained at the onset of labor, and the administration of 100,000 units of penicillin, prophylactically, resulted in an afebrile and uncomplicated puerperium. Smears on discharge from the hospital were negative.

There have been no additional cases of ophthalmia neonatorum. In the one instance reported previously cultures were negative in twenty-four hours following local and systemic treatment.

Pyelitis.—One patient whose urine culture was positive for streptococci was given penicillin and there was definite improvement in her symptomatology.

Pelvic Cellulitis.—One case of massive pelvic cellulitis following manual removal of the placenta showed no improvement in spite of adequate penicillin. There have been no additional cases.

Peripheral Phlebitis.—Penicillin was given to three patients for peripheral phlebitis. In two of these

patients the temperature dropped to normal within forty-eight hours. As supplementary therapy, a parasympathetic block preceded the penicillin in one instance. The third patient showed no improvement. This short series is not conclusive.

Acute Suppurative Mastitis.—To the one case of acute suppurative mastitis previously reported, we are able to add five additional cases. *Staphylococcus aureus* was the infecting organism in four instances. No culture was taken in the fifth. Penicillin dosage ranged from 250,000 to 545,000 units. Four of these patients left the hospital within five days; the fifth left on the eighth day. The breasts were apparently free of infection on discharge.

Omphalitis.—Two cases of omphalitis in the newborn are reported for the first time in this study. The first baby on the eighth day developed a purulent umbilical discharge which on culture contained *Staphylococcus aureus*, *albus*, and green streptococci. Induration and erythema developed around the umbilicus and a cord-like induration running upward toward the liver subsequently appeared. The temperature rose to 104 F. The baby was given 5000 units of penicillin every third hour and sulfadiazine gr. 1 at the same interval. The temperature was normal within twenty-four hours. The baby was apparently cured on the fifth day following institution of therapy. The total penicillin dosage was 105,000 units supplemented by 12 gr. of sulfadiazine.

In the second case, on the ninth neonatal day, the same symptomatology was present. Culture from the umbilicus demonstrated *Staphylococcus albus*, non-hemolytic streptococci, and diphtheroid bacilli. Following 95,000 units of penicillin the infection was entirely gone.

Summary

A total series of 112 patients have been treated with penicillin.

Penicillin was given to 25 patients for early acute mastitis.

Penicillin was used prophylactically in 13 patients subjected to cesarean section following complicated labors. It was also given to 13 patients following cesarean section when clinical evidence of infection was present.

Twenty patients with postpartum infection have been treated.

Twenty-three septic abortions are included in this report.

Five cases of known gonorrheal infection, one of pyelitis, one of pelvic cellulitis, three of peripheral thrombophlebitis, and six of acute suppurative mastitis are also reported.

Two instances of acute omphalitis in the newborn have been added.

Conclusions

1. In our original report we felt that penicillin deserved serious consideration in obstetric complications due to infection, potential or actual. This assumption is corroborated by the additional material presented.

2. All cases of early acute mastitis were cured within forty-eight hours.

3. The prophylactic administration of penicillin following prolonged rupture of membranes, inertial labors, and in other patients potentially infected has not failed to assure a smooth convalescence and has shortened the period of hospitalization. Following cesarean section, especially in infected and potentially infected cases, the margin of safety is undoubtedly increased.

4. The treatment of active infections following cesarean section has been as effective in this larger series as in the preliminary group.

5. In septic abortion, penicillin was effective and its use was unattended by the undesirable features of sulfonamide therapy. The presence of severe grades of anemia in these patients appears not to contraindicate penicillin therapy.

6. Previously reported efficacy in the treatment of gonorrheal infection is further substantiated.

7. Pyelitis due to streptococcal infection may benefit by penicillin therapy.

8. No additional cases of postpartum pelvic cellulitis have been encountered. We cannot draw any conclusions from our experience with this pathologic entity.

9. The administration of penicillin in postpartum peripheral thrombophlebitis deserves further investigation.

10. Penicillin has proved of value in the postoperative treatment of late acute suppurative mastitis.

11. Omphalitis in the newborn apparently responds quickly to penicillin. This therapy should greatly reduce the infant mortality due to this extremely dangerous infection.

12. The conclusions drawn in our preliminary survey have been corroborated in this larger series. The absence of any mortality and the decrease in hospital stay have been most gratifying. As pointed out in our first paper, an occasional penicillin-resistant organism may be encountered and we would recommend investigation of the organism for penicillin sensitivity when therapy does not seem to be securing satisfactory results.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Florence, S. C.

Subscription Price

\$3.00 per Year

MARCH, 1946

ANNUAL MEETING

The annual meeting will be held at Myrtle Beach, April 30, May 1 and 2. The change was made by Council at the suggestion of the Greenville doctors when it was found that the hotels in Greenville would not accommodate the crowd.

The meeting will be held at the Ocean Forest Hotel and reservations should be made with the manager.

A CENTURY OLD

In two years we will be celebrating the one hundredth birthday of our Association and it is not too soon to be making plans for the occasion. Since the Association was born in Charleston, it would seem appropriate for us to plan to hold the 1948 annual session in that city. Certainly some type of historical commission should be established to prepare a comprehensive history of the organization and of its activities. This will be no small task. Many ideas will be advanced as to the type of program which should be presented on that occasion and as to the choice of visiting speakers. It will take time to gather these ideas and to weld them into a cohesive plan.

Yes, we will soon be a hundred years old and we should begin to prepare for our birthday party.

EXCHANGE DEPARTMENT

In this issue we are beginning a new Department which we hope will become one of the most popular features of the Journal. We refer to the Exchange Department.

There are two reasons for this new project. Each state medical association—either alone or in conjunction with two or three neighboring state associations—publishes a monthly medical journal. Through a reciprocal agreement, each of these journals comes to our editorial office. There is much in these publications which could be read with profit and interest by our members. Such are the items which we intend to present.

In the second place, it is becoming difficult to maintain and to improve the scientific section of our Journal with contributions limited to our own members. Papers which usually come from the annual scientific session of our Association have not been forthcoming during the war—since we have had no such meeting. (The coming meeting at Myrtle Beach will help to change this.) Physicians have been extremely busy during the past few years and have pushed writing to one side as they gave their full time to their patients. Many of our colleagues who are returning from the service are keen observers and good writers, but the problem of readjustment and getting back into harness will consume their activities for the immediate future.

To tide us over this difficult period, therefore, we will present our Exchange Department, and if it becomes popular—as we believe it will—we will continue it as a permanent part of the Journal. We invite comments and criticism.

MEMBERS OF CONGRESS

Those who represent us in Washington at the present time are:

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Olin D. Johnston, Spartanburg, S. C.

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Sixth District—John L. McMillan, Florence, S. C. Counties: Darlington, Dillon, Florence, Georgetown, Horry, Lee, Marion, Marlboro, Williamsburg.

SOUTH CAROLINA MEDICAL ASSOCIATION
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
 January 1, 1945 to December 31, 1945

Balance in Bank—January 1, 1945:

Guaranty Bank & Trust Co.

\$ 2,814.13

Revenue Receipts:

Membership Dues	\$ 4,693.00	
Subscription Dues	2,047.00	
Advertising	7,852.58	
Interest Earned	308.04	
Miscellaneous Income	10.50	
Social Security	30.00	
Withholding Taxes	589.20	15,530.32
Gross Receipts		\$18,344.45

Disbursements:

Audit & Legal	\$ 65.00	
Convention Expense	425.96	
Dues & Subscriptions	50.00	
Heat, Light & Water	60.97	
Insurance	12.90	
Miscellaneous Expense	145.55	
Office Supplies	347.86	
Printing	4,676.35	
Rents	303.00	
Salary—Secretary & Editor	2,100.00	
Salary—Stenographer	900.00	
Postage	70.00	
Taxes & License	30.00	
Telephone	205.31	
Travel Expense	182.02	
Bank Charge	2.80	
Ten Point Program	1,000.00	

Withholding Taxes:

Social Security	30.00	
Withholding Taxes	560.70	
Office Fixtures	126.00	

Total Disbursements

11,294.42

Balance

\$ 7,050.03

Balance—Ten Point Program

90.77

Balance per Banks—December 31, 1945

\$ 7,140.80

SOUTH CAROLINA MEDICAL ASSOCIATION
BALANCE SHEET
 December 31, 1945

ASSETS			
Petty Cash		\$	10.00
Guaranty Bank & Trust Co.			7,050.03
S. C. National Bank			90.77
Accounts Receivable			1,058.41
Deposits Receivable			3.00
Investment:			
Defense Bonds	\$ 6,500.00		.
Peoples Federal Savings & Loan	500.00	7,000.00	
Office Furniture & Fixtures			1,338.50
Total Assets			<u>\$16,550.71</u>
LIABILITIES			
Social Security		\$	23.01
Withholding Taxes			282.90
Total Liabilities			<u>\$ 305.91</u>
SURPLUS			
Balance—January 1, 1945		\$14,859.24	
Excess of Revenue over Expense		5,333.40	
Total		<u>\$20,192.64</u>	
Less—Ten Point Program (Deficit)		3,947.84	
Total Surplus			16,244.80
Total Liabilities and Surplus			<u>\$16,550.71</u>

We have examined the treasurers records of the South Carolina Medical Association for the year ended December 31, 1945, and,

We certify that in our opinions, the above Balance Sheet and accompanying statement of Revenue and Expense sets forth the financial condition of the South Carolina Medical Association, Florence, South Carolina, as at December 31, 1945, and the results of its income and expense for the year ended on that date.

Respectfully submitted,

Florence, South Carolina
 January 24, 1946

JAILLETTE & BRUNSON
 Public Accountants

TEN POINT PROGRAM
SOUTH CAROLINA MEDICAL ASSOCIATION
STATEMENT OF RECEIPTS AND DISBURSEMENTS
 January 1, 1945 to December 31, 1945

Balance in Bank January 1, 1945:			
South Carolina National Bank			\$ 6,135.81
Receipts:			
Contributions	\$	105.00	
Advances Medical Association		1,000.00	
Withholding Taxes		606.70	
Social Security		61.63	1,773.33
Gross Receipts			<u>\$ 7,909.14</u>
Disbursements:			
Office Expenses & Supplies	\$	259.69	
Audit		25.00	
Travel Expense		636.50	
Salary—Executive Director		5,000.00	
Salary—Stenographer		1,163.32	
Taxes		59.98	
Withholding Taxes		613.90	
Social Security		59.98	
Total Disbursements			<u>7,818.37</u>
Balance per Bank, December 31, 1945			<u>\$ 90.77</u>

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

HEARINGS SET ON WAGNER-MURRAY-DINGELL BILL

Information has just been received that a date has been definitely set for the beginning of hearings on the Wagner-Murray-Dingell Bill (S 1606) before the Senate Committee on Education and Labor. April 1 is the date fixed by the committee. By that time, the doctors will have been well informed through the press and other channels, and the hearings will probably be underway when this appears.

Senator Olin D. Johnston is a member of this Committee on Education and Labor, and the interest of South Carolinians generally and the members of the South Carolina Medical Association in the progress and developments at the hearings will be keener and, incidentally, of greater importance than may be the case with certain states which do not have a representative on the committee.

This is a very significant phase of the contest on this important issue. One has only to reflect upon the experience of the past few months and other incidents throughout the years to realize the effect of Senate committee hearings in influencing public opinion and the opportunity which they present for the airing of every conceivable viewpoint and attitude toward the matter under consideration. It will be well for the profession to keep these hearings in mind, to follow the press accounts closely, for the developments in the weeks immediately following March 18th will serve as strong indications of what is to come in the form of definite legislation.

GENERAL ASSEMBLY RECEIVES EXPANSION PROGRAM

On Wednesday, February 20, the Program for Expansion of the Medical College of South Carolina, outlined and arranged by Dr. Lynch and the faculty and Board of Trustees, and endorsed by the South Carolina Medical Association, was presented to a joint meeting of the Senate and House of Representatives in the State House at Columbia. According to arrangements made in advance, the joint session convened at 12 o'clock noon, and the presentation on behalf of the medical association was made by Dr. James McLeod, Chairman of the Committee which has been engaged for the past several months in the study of the program.

Dr. McLeod was escorted to the speaker's platform by the physicians in the General Assembly and members of the Florence County Delegation, and presented by Edgar A. Brown, President pro tem of the Senate. In a direct, plainly worded, statement, Dr. McLeod informed the legislative members of the college's needs, the proposed plan of expansion, and the amount that would be required by way of appro-

priation from the state in order to carry the program into effect. He stressed the findings contained in the report of Dr. Sanger of Peabody Institute, who made an investigation under the direction and authorization of the State Research Planning and Development Commission.

A majority of the Committee of Forty-nine were on hand, together with a number of other doctors from throughout the state, and their presence in the lobby previous to the joint session and in the House when the matter was presented, attested the interest of the profession and its solid backing of the Expansion Program which is so vital to the best interest of the college and of the cause of medicine in South Carolina.

From all appearances, the presentation was well received by members of the General Assembly and the public alike. It is certain that a very favorable atmosphere was created and that the prospect for favorable action by the legislative body was definitely improved. In fact, the press of the following day carried statements to the effect that the program had been considered by the powerful Senate Finance Committee and would have the support of this group. It was not immediately certain, however, whether the program would be introduced as a new bill or otherwise. This phase of the matter, of course, is in the hands of competent and experienced legislators and their advisors, and early favorable action is anticipated.

A DOCTOR REVIEWS THE WAGNER BILL

We quote with pride the following extract from the address of a South Carolinian, Dr. J. W. Jervey, Jr., as Chairman of the section on Ophthalmology and Otolaryngology, Southern Medical Association, November, 1945. Dr. Jervey's observations are timely and represent a fair-minded attitude which should be that of the whole profession.

"The topic most discussed by the medical profession at present is that of so-called socialized, state, or legislated medicine. Many physicians, as soon as this subject is broached immediately get hot under the collar. Why? Let us examine the facts.

"If proposed legislation has done nothing else it has made the medical profession sit up and take notice of needs in general as regards medical care. We must all assume the obligations and take advantages of the privileges which we knew were to be ours when we undertook the study of medicine. Reference here is to the entirely inadequate care of the indigent in well organized communities where all too frequently busy practitioners are unwilling to give of their time and experience to clinic work. This is not hearsay, but an indictment brought as the

result of personal knowledge. The aim of the government is to furnish adequate medical care. The challenge to our profession is to meet the need without the necessity for coercion. Much thought has been given to this matter, and plans abound. Many of them are good. My beloved state of South Carolina has come forward with a ten-point program which has received national attention and commendation.

"There was much argument last year over the Wagner-Murray Bill. There will be much again this year over Senate Bill No. 1050. Yet how many of the physicians who argue so loudly are accurately informed as to the contents of these bills? To begin with there is nothing in S-1050 that remotely attempts to force anything upon physicians nor are all of its objectives wholly diabolical. On the contrary there are many things in the Wagner-Murray-Dingell Bill which are exceedingly desirable and therefore commendable. Surely we are in need of better and greatly extended health services, better housing and sanitation, and better hospital facilities. That is not to say that passage as it now stands is advocated, but it has its points.

"As I see it, beyond the deplorable fact that it will further increase taxes, there are three main objections to the bill. The most important of these is that there is in it absolutely no provision for the care of the indigent between the ages of 18 and 65 years. To me this means that the bill was essentially political or selfish in origin. If proponents of the bill care to argue it was intended that the privilege of caring for the poor be left as heretofore with local institutions and physicians, then the care of those who can pay might well be left there also.

"Mr. Wagner naively draws a fine distinction in referring to the 8 per cent of our personal incomes necessary to insure the success of this program as a social security premium and not a tax. If there is a practical difference it will take a high powered microscope to detect it.

"The second objection is that medical insurance is placed on a compulsory and not on a voluntary basis. Very sensibly the federal government offered a life

insurance policy to soldiers and sailors in service, but also very wisely they were not required to take it. Why then should a man be forced to take out a medical insurance policy he does not want? For the good of the whole? Impossible, for the indigent are not provided for and only those who have jobs may receive benefits.

"Thirdly, contrary to Mr. Wagner's assurances, there is in the bill definite restriction on the choice of physician by the patient, and he may have to pay more than he should to obtain the service he desires. For example, John Jones is a patient of yours. Rightly or wrongly he believes that you are the 'best doctor in the whole United States.' You do not take on this government work, but when little Johnny gets sick his father wants you to take care of him and pays for it. Mr. Jones has been forced to pay twice, once from his pay envelope for something he did not want and would not have, and again from his purse for the service desired and obtained.

"Furthermore, by the terms of this bill you as a specialist can be consulted only by request of the patient's family physician! He will be loath to give up his small fee in your favor and will more often than he does today unfortunately try more and more to manage conditions the best treatment for which he is not in a position to know.

"So, we have before us this matter of medical care, a tremendous problem. How shall we attack it? First we must think clearly and carefully about it, and each must lend an idea or hand where possible in its solution. In addition we must keep cool and not jump frantically to false conclusions as to what somebody is trying to do to the medical profession. Rather we should give much thought and attention to what the medical profession is doing to itself.

"The truth is this: and I quote again from Robert E. Lee:

"The march of Providence is so slow and our desires so impatient; the work of progress is immense and our means of aiding it so feeble; the life of humanity so long, that of the individual so brief, that we often see only the ebb of the

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advancing wave and are thus discouraged. It is history that teaches us to hope.'

"This discussion does not presume to dictate in any instance; rather it has been my desire to arouse interest or stimulate thought. All too elusive answers are far from clear, but to find them this suggestion is made; we must constantly undertake the apparently impossible and we will frequently find that ways and means become available when a problem is approached with an open mind and with a warm heart. Nothing must ever be too hard for us to try. The more difficult a thing seems the more effort must be exerted to remove all obstacles to a satisfactory solution. When we have done this we shall not have failed. And what will we have? A bit of contentment, a measure of peace, the love of our fellow men, and what is infinitely more important, love for our fellow men."

(Southern Medical Journal, January 1946)

SUGGESTED STANDARDS OF ACCEPTANCE FOR MEDICAL CARE PLANS

We are uncertain about the extent to which the AMA News Letters are distributed among the members of the profession generally. It is possible that most of the doctors have received through the mail the material which follows immediately below. Realizing, however, the human and professional tendency to disregard mimeographed and other material which reaches one's desk at regular intervals, we doubt that the letters, if received, have been given very close attention.

The material is of such significance that it should be preserved. We believe the subject with which it deals is of the utmost importance. It has been stressed repeatedly in these columns. We think the principle and the proposed organizations with which it deals contain the answer to the profession's present economic problem, if there is an answer. For these reasons, the suggested standards as approved by the AMA Council on Medical Service and Public Relations are printed in full below.

"Development of plans affecting the distribution of medical care, in accordance with the principles adopted by the House of Delegates, is one of the principal functions of the Council on Medical Service and Public Relations. First in importance in the development of plans affecting the provision of medical care is the utilization of the prepayment method to help spread medical and surgical costs.

"The Council on Medical Service and Public Relations suggests that special recognition be granted to plans organized and operated in accordance with standards which adequately protect the interest of the public and the medical profession.

"In granting this recognition the Council will consider each prepayment medical care plan in the light of established knowledge, authoritative opinion, and according to standards adopted from time to time by the Council in the interest of the public. Plans that conform with the requirements thus formulated will

be accepted by the Council.

"Under the conditions defined in the following paragraphs, the Council grants the right to print its seal on all official papers of accepted plans and in any promotional literature or display material used by these plans.

"This official seal should appear without comment on its significance unless such comment has been previously approved by the Council. A statement proposed for such use follows: "the seal of acceptance denotes that (name of plan) has been accepted within the standards set forth by the Council on Medical Service of the American Medical Association.

"The acceptance of a plan and the seal of the Council are intended to signify that the plan conforms with or meets the following standards or requirements:

LOCAL APPROVAL (1) The prepayment plan must have the approval of the state medical association or if local, of the county medical society in whose area it operates.

PROFESSIONAL CONTROL (2) The Medical profession should assume responsibility for the medical services included in the benefits; the medical profession is qualified legally and by education to accept responsibility for the character of the medical services rendered.

ARBITRATION (3) Provision should be made for a medical director acceptable to the county or state medical society, or a committee appointed by either of these groups, to adjust difficulties and complaints. The medical director or committee members may be paid on a per diem basis for the time involved in handling such matters.

FREE CHOICE OF PHYSICIAN (4) There should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give service under the conditions established.

PATIENT-PHYSICIAN RELATIONSHIP (5) The method of giving the service must retain the personal, confidential relationship between the patient and the physician.

(6) The plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber. Honesty of purpose and sincere consideration of mutual interests on the part of the subscribers, the physicians and the plans are presupposed as necessary considerations for successful operation.

(7) The dues from subscribers through premium rates should be adequate to provide for the benefits offered and the risks involved.

In determining such factors the Council will utilize the experience of those plans that are and have been operating successfully, but will not discourage experiments in other types of coverage provided such experiments are limited in scope and capable of scientific evaluations.

STATEMENT OF BENEFITS (8) These benefits may be in terms of cash indemnity or service

"don't smoke"...

*IS ADVICE HARD FOR
PATIENTS TO SWALLOW!*

May we suggest, instead,
SMOKE "PHILIP MORRIS"?
Tests* showed 3 out of every
4 cases of smokers' cough
cleared on changing to
PHILIP MORRIS. Why not
observe the results for
yourself?

**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY
DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

units. Where benefits are paid in cash to the subscriber it must be clearly stated that these benefits are for the purpose of assisting in paying the charges incurred for medical service and do not necessarily cover the entire cost of medical service, except under specified conditions.

(9) Subscribers' contracts must state clearly the benefits and conditions under which medical services will be provided or cash indemnities paid. All exclusions, waiting periods, and deductible provisions must be clearly indicated in the promotional literature and in the contracts.

PROMOTION (10) Promotional activities must be reasonable without extravagant or misleading statements concerning the benefits to the subscribers. In approving promotional material the Council will endeavor to indicate the type of statements which are acceptable and the nature of those considered objectionable. It is not the function of the Council to edit all copy word for word and sentence for sentence, but rather to indicate the general type of revision required in any given piece of literature. It expects the spirit and intent of such objections to be observed in the remainder of the copy not specifically criticized. Promotional activities will include any devices for informing the public or the profession.

ENROLLMENT (11) Enrollment practices shall be based on sound actuarial principles such as will not expose the plan to adverse selection. Group enrollment is recommended until further experience warrants the acceptance of individuals.

(12) It is understood that the plan of organization will conform with state statutes and that the plan will operate on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision should be under the appropriate state authority.

(13) Each accepted plan must submit periodic reports of financial and enrollment experience in the manner prescribed by the Council.

DURATION OF ACCEPTANCE. Acceptance of plans by the Council will be for a period of two years or until revoked (provided they comply with the standards during this period) at the end of which all contracts and financial statements be re-examined. A shorter period of approval may be granted at the discretion of the Council. Any changes in contracts or literature during the period of acceptance must be submitted to the Council for review.

RECOMMENDATIONS AS TO PREPAYMENT MEDICAL CARE PLAN

The following statement of recommendations of the Council on Medical Service and Public Relations of the AMA has been approved by the Board of Trustees and released by the Council. Any subject that is regarded with such importance by the two bodies referred to, deserves the thoughtful consideration and, in our opinion, active steps toward implementation by the state medical associations, partic-

ularly in those states where no plan or organization exists. South Carolina is prominent among this group of states.

"The Council on Medical Service and Public Relations recommends the employment of a Director of its Division of Prepayment Medical Care Plans and the necessary staff. It is recommended that the Council appoint an Advisory Committee representing medical care plans and their associations.

"The Council has determined standards for medical care plans, a copy of which is attached. Plans which meet these standards shall be entitled to the use of the Council Seal during the period of their approval.

"The Director of the Division of Prepayment Medical Care Plans of the Council on Medical Service and Public Relations with his staff and with the assistance and cooperation of the Advisory Committee, the State Medical Societies and the Association of Medical Care Plans shall be available to assist in developing plans, increasing the number of persons covered by already existing plans and facilitating reciprocity among them.

The Council believes that responsibility for the development of medical care plans rests with state and county medical societies. Stimulation, coordination and federation of such plans under the instructions of the House of Delegates is deemed to be the function of the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association.

"The duty of the Advisory Committee shall be to advise the Director of Prepayment Medical Care Plans and the Council on the methods of implementing the program and, on approval of the Council, the Director of Prepayment Medical Care Plans will undertake the functions described in paragraph 3.

"The Advisory Committee shall consist of five members, appointed for one year. For the first year it is suggested that the following comprise the committee: Mr. Jay Ketchum, Dr. F. Feierabend, Dr. Herbert Bauckus, Mr. William Bowman and Mr. Charles Crownhart.

"A tentative cost of this program is estimated at \$50,000 for the first year."

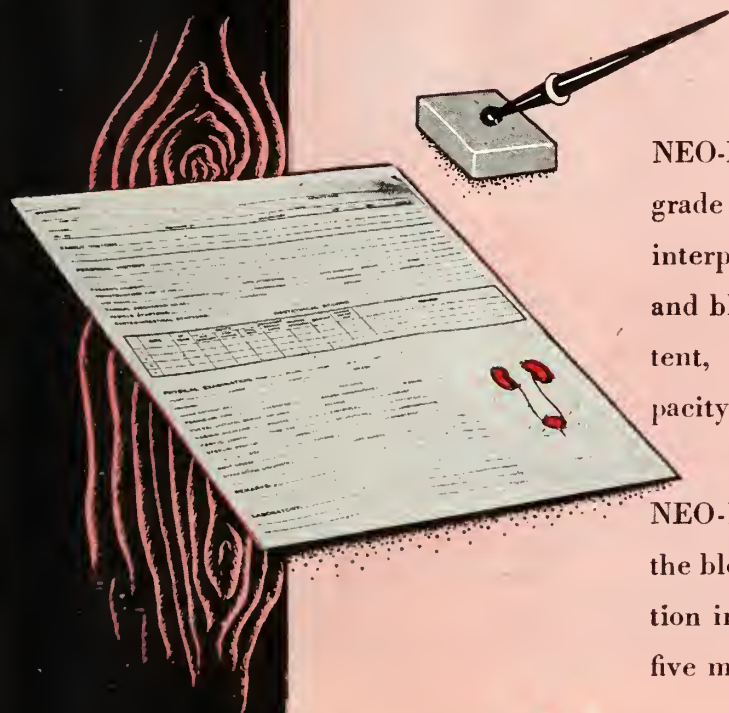
(Compare the foregoing with the proposal for a national organization of prepayment medical care plans by Dr. Julian Price in the January issue of this Journal.)

THE PREVALENCE OF POLLS

Of course, we may be entirely wrong, as we frequently are, but somehow the growing tendency to take a poll on practically everything from the prospects of the future presidential candidates, to the extent of use of infants' accessories, has never appealed greatly to us. Despite occasional evidence in results of the apparent accuracy of the poll, we have always doubted their effectiveness and are inclined to think that such results are usually more or less coincidental.


At any rate, it is certainly true, and this we con-

A clear urographic record



NEO-IOPAX for intravenous and retrograde urography produces clear, easily-interpreted records of kidney, ureter and bladder pathology. Its iodine content, 51.38% is optimal for radiopacity and is well tolerated.

NEO-IOPAX is cleared rapidly from the blood and found in high concentration in the urinary tract within two to five minutes after injection.

 *Neo-Iopax*

A solution of pure disodium N-methyl-3,5-diiodo-chelidamate, in 50% and 75% concentrations. For retrograde pyelography, a 20% concentration may be prepared by diluting with distilled water.

TRADE-MARK NEO-IOPAX — REG. U. S. PAT. OFF.



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IN CANADA, SCHERING CORPORATION, LIMITED, MONTREAL

tend goes far to prove our point, that the polls are frequently "poles apart." For instance, about a year and a half ago Foote, Cone and Belding, a firm with long experience in evaluating public opinion, conducted an inquiry in the nature of a poll in California and also in Michigan, under the sponsorship of the medical organizations of the respective states and came up with results which were highly publicized as tending to show the majority opinion among the people "polled" in those states against compulsory insurance under control of the government. The views on related questions varied, the general impression being that some change was in order, although such changes were desired on a voluntary basis.

The National Physicians' Committee, as we recall, have conducted, or at least have reported the results of, certain polls tending to show the same opinion. In the January 5th issue of "New York Medicine," publication of the Medical Society of the County of New York, there is, however, the report of a survey by the Opinion Research Corporation of Princeton, N. J., conducted at the request of the National Physicians' Committee, which seems to point in the other direction. According to this report as presented by the president of Opinion Research: "2 out of 3 of our fellow citizens are in favor of prepaid medical care, and 77% believe that something can be done to ease the financial strain of medical expenses.

"45 out of every 100 persons interviewed expressed a preference for government sponsorship of medical care programs, while 43 preferred private sponsorship."

And then comes the American Magazine in its January issue, 1946, and undertakes to review once more the need for compulsory health insurance. The *American's* poll, it states, was of a considerable number of "experts" and it found that 99% believe that the American people should be protected by some form of health insurance. Analyzing the figures further, the *American* reports that 60% of its expert opinion was to the effect that insurance should be compulsory and operated by the government, 40% that it should be private and voluntary.

Assuming that the polls conducted and which have come to our attention within the past two or three years have been accurate, they would certainly seem to indicate a definite trend away from the idea of free and open practice of medicine, toward a national system of prepayment of medical care, and, further, toward such system on a compulsory basis, administered by the government. But, as indicated above, we have always held and maintain to the present writing, our serious doubt of such accuracy.

It was our belief on examining the results of the first polls which seemed to indicate a strong preference for the retention of the present status, that questions could be framed in such manner and sequence as to develop the result which might have been desired by the organizations sponsoring the survey. We are more fully convinced of this after reading the results

of some of the surveys not conducted by the medical organizations or under their sponsorship. After all, if the poll of the American Magazine is truly accurate within its scope, we may console ourselves with the fact that it was confined to the opinion of "experts" attempting evidently to gauge public opinion in the United States.

To question at random any limited group, however selected, obtain their answers to specified questions and compile the results so as to determine what the majority think, is one thing; to contact "experts" in the art of determining public opinion, is quite another. We who are definitely not expert on the subject prefer to reserve our doubts of the accuracy of the polls of the people, or the polls of those who poll the people.

EDITORIAL OPINION RE PRESIDENT'S HEALTH INSURANCE PROPOSAL

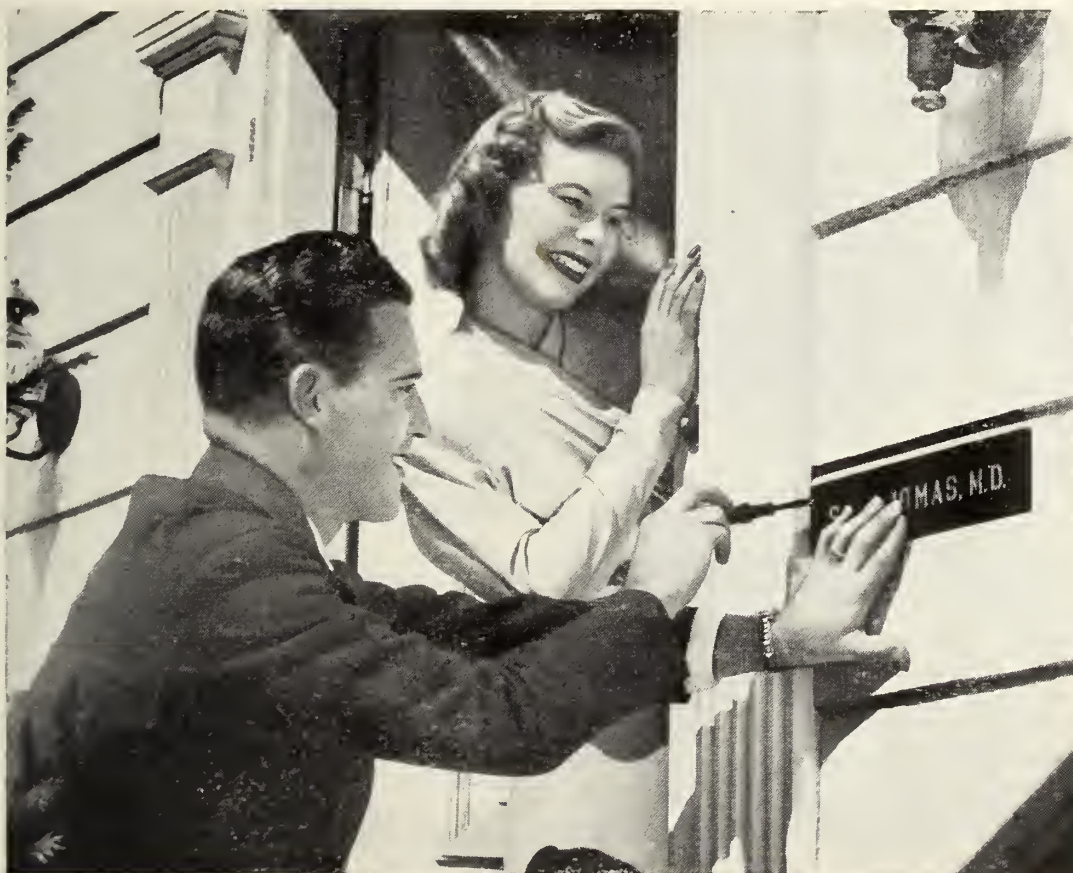
The New York Times, November 21, 1945, inquires about the cost:

What of the cost of the President's program? Here doubts will necessarily arise. We are presented with the familiar argument that with a deduction of 4 per cent from salaries up to \$3,600 we shall pay little more for medical care than we do now, which is about 2.8 billions annually. The argument seems much too cheerful. It overlooks the fact that in normal times 50,000,000 lived in families which could not call a doctor except in cases of catastrophic illness. With medical care more uniformly distributed and with at least 100,000,000 insured, physicians will be consulted more and more. The cost of insured medical care may therefore well amount to four billions annually. Add the cost of building and operating the proposed hospitals and medical centers at Federal and State expense and lastly money allowances when sickness or disability prevents a man from working, and no one knows what the ultimate figure may be.

The Shreveport (Louisiana) Times, of December 9, 1945, supports the position of the American Medical Association unequivocally. It points out that:

The Journal of the A.M.A. makes the shocking revelation that neither President Truman nor anyone else sponsoring the insurance plan ever has consulted any representative of the American Medical Association concerning it, although the A.M.A. membership is made up of 125,000 of the nation's recognizedly reputable physicians and surgeons!

It is almost unbelievable that the Washington administration itself would endorse and propose a plan to be paid for by money from the pocket of every taxpayer and affecting the physical welfare of every working person without some conference with representatives of the biggest medical organization in the world. Yet that seems to be the fact and the only conclusion that seems logical is that once again a wolflike "social reform"



There is a Doctor in the House

*—and it took a minimum
of \$15,000 and 7 years'
hard work and study
to get him there!*

● Proudly he “hangs out his shingle,” symbol of his right to engage in the practice of medicine and surgery. But to a doctor it is more than a right: it is a privilege — the privilege of serving mankind, of helping his fellow man to a longer, healthier, and happier life.



According to a recent
nationwide survey:

**More Doctors
Smoke Camels**
than any other cigarette

created by dreaming theorizers is being offered the nation in lamb's clothing.

The Chicago Daily News, November 21, 1945, asks some pertinent questions:

In any case, it would be silly to make up our minds about a bill on account of the names it might be called. The question is: what would it actually do; what would it actually cost; is it worth what it would cost; can we afford what it would cost, and what would its secondary effects be on medical practice and human welfare?

L. A. Mack, publisher of the *Weekly Underwriter*, in its issue of November 24, discussed the matter at

some length. He asks these questions:

How many of us are going to keep up our disability insurance in privately operated insurance companies if the government is going to soak us \$144 a year for the rest of our lives? How long will the privately operated insurance companies last if this happens? How long before the government steps into the life insurance business too? When did we, the people, delegate to the federal government the right to enter into business in competition with existing, privately operated enterprises? Where is the Constitutional authority for this sort of thing?

(*Insurance Economics Surveys*, February, 1946)

NEWS ITEMS

Dr. William S. Evans has received his discharge from the Army and has resumed his former practice in Bennettsville.

Dr. Evans entered service in 1942 and was assigned to the 38th Evacuation hospital, with which group he ministered to the wounded in England, Africa and Italy. After eighteen months overseas he was returned to the States and assigned to the station hospital at Camp Davis. At the closing of this camp he was transferred to Camp Ellis, Ill., and later Battle Creek.

Dr. Evans, who held the rank of captain in the army, holds the Victory ribbon, American Theater and European-North African ribbons with three campaign stars, also the bronze arrowhead for D-Day landing in Africa.

Dr. David A. Wilson, formerly of East Liverpool, Ohio, and of Duke Hospital at Durham, N. C., has opened offices at 209 East Coffee Street, Greenville, for the practice of surgery.

Dr. Wilson was graduated from Ohio State University Medical School in 1938. He was resident, specializing in diseases of the chest, for one year at Franklin County Hospital, Columbus, Ohio, and was successively intern, assistant resident, resident and instructor in surgery at Duke Hospital from 1939 to 1946.

Dr. William S. Scott has announced that he is resuming the general practice of medicine at his former office, 139½ West Main Street, Spartanburg.

Dr. Scott, who was a captain in the Army Medical Corps, was recently discharged after almost four years of service in this country and overseas. He was stationed for a time at Lawson General Hospital in Atlanta and later was with the 216th General Hospital for eighteen months in England, France and Germany.

Dr. William Schulze, formerly with the Duke University School of Medicine, is returning to private practice after four years duty with the Medical Corps, Army of the United States, where he served as Chief of the Medical Service of both numbered and named General Hospitals. He has located in Greenville where he will be associated with Dr. Hugh Smith in internal medicine.

Dr. J. W. Brunson has returned from the wars and resumed his practice at Camden.

Dr. Gertrude Holmes has been discharged from the army and is planning to go to Philadelphia for refresher courses in X-ray diagnosis.

Dr. A. F. Burnside has been elected President of the Columbia Medical History Club for the year 1946. Dr. L. E. Madden is Vice President and Dr. B. N. Miller is Secretary-Treasurer.

Dr. J. Warren White of Greenville has been elected a fellow of the Southern Surgical Association. Congratulations, Dr. White.

The following Columbia physicians have received their discharges from the service: Dr. R. B. McNulty, Dr. Frank Owens, Dr. J. B. Workman and Dr. C. M. Lide.

Dr. John F. Robinson is now associated with Dr. Henry Ross of Greenville in the practice of medicine.

SOUTHEASTERN ALLERGY ASSOCIATION

The first meeting of the Southeastern Allergy Association will be held in Atlanta (at the Atlanta-Biltmore Hotel), Saturday, March 30, and Sunday, March 31.

The business meeting will begin at ten a.m., Saturday with Dr. Hal McCluney Davison presiding.

Luncheon at noon will be followed by a scientific session with the following program:

1. "Contact Allergy"—by Dr. Oscar Swineford.
2. "Headaches"—by Dr. William Crowe.
3. "Preparation of Extracts"—by Dr. Edna Pennington.

There will be a banquet at night which the Atlanta men are planning. (Dinner clothes will be optional for the banquet.)

The Sunday morning session, to begin at ten a.m., will include:

1. "The Relationship Between Immediate and Delayed Skin Reactions"—by Dr. John Jacobs.
2. "Allergy in Childhood"—by Dr. Susan Dees.
3. "Allergic Rhinitis"—by Dr. Randolph Graham.

Each paper will have two discussions and then will be thrown open to all. These discussants will be named in a later bulletin.

This meeting is open to everyone interested in allergy regardless of the type practice one has.

In order that there may be some idea of the number planning to attend this meeting, you are asked to write to the secretary, Dr. Katherine Baylis Machnis, 1515 Bull Street, Columbia, S. C.

OPHTHALMOLOGICAL SEMINAR—EMORY UNIVERSITY

Emory University will celebrate the One Hundredth Anniversary of the birth of ABNER WELLBORN CALHOUN, L.D., L.L.D., born April 16, 1845, died August 21, 1910, the first professor of Ophthalmology of the Atlanta Medical College.

You are cordially invited to be the guest of Emory University at an OPHTHALMOLOGICAL SEMINAR to be held in Atlanta April 4, 5, 6, 1946.

Program

Thursday, April 4, 1946
ACADEMY OF MEDICINE

- 6:30 P.M. Buffet Supper
7:30 P.M. Dr. James Edgar Paullin—Dedication of Auditorium
8:00 P.M. Dr. Frank B. Walsh—Myasthenia Gravis
9:00 P.M. Dr. Walter I. Lillie—Medical Ophthalmology

Friday, April 5, 1945

GRADY HOSPITAL LECTURE ROOM

- 10:00 A.M. Dr. Walter I. Lillie—Diplopia
11:00 A.M. Dr. William Benedict—The Clinical Meaning of Exophthalmos
Luncheon. Guest of Grady Hospital
ACADEMY OF MEDICINE
3:00 P.M. Dr. Derrick Vail—Eye Changes in Diabetes
1:00 P.M. Dr. Frank B. Walsh—Naso-pharyngeal Tumors
6:30 P.M. Dinner. Biltmore Hotel, Guest of Emory University
ACADEMY OF MEDICINE

8:00 P.M. Dr. Parker Heath—Ocular Therapeutics in Glaucoma

9:00 P.M. Dr. John Dunnington—Treatment of Detachment of the Retina
Saturday, April 6, 1946

ACADEMY OF MEDICINE

10:00 A.M. Dr. William Benedict—Glaucoma in Diabetes

11:00 A.M. Dr. John Dunnington—Surgical Treatment of the Vertical Deviations.

1:00 P.M. Luncheon. Biltmore Hotel. Guest Dept. of Ophthalmology
ACADEMY OF MEDICINE

2:30 P.M. Dr. Parker Heath—Random Notes on Ocular Surgery.

3:30 P.M. Dr. Frank B. Walsh—Ocular Signs of Subdural Hematoma

4:30 P.M. Dr. Walter I. Lillie—The Clinical Diagnosis of Retrobulbar Neuritis. Academy of Medicine

8:00 P.M. Dr. William Benedict—Preparation of the Patient for Cataract Operation.

9:00 P.M. Dr. Derrick Vail. The Circulation of the Optic Nerve and Its Fluence on Disease.

Dr. Eugene Stead, Dean, 50 Armstrong Street, S. E., Atlanta, Ga.

CORRESPONDENCE

January 24, 1946

Dr. Julian Price
Florence, South Carolina

My Dear Julian:

There is certainly an impression throughout the medical profession, and in the mind of the general lay public, that specialization in medicine is of rather recent origin. We often find ourselves thinking of the good old days of grandpa, and even bemoan his passing, not only because he was a friend of the family, a wise counselor, etc., but because in the later days we must consult three or four practitioners instead of just the one.

In looking over some quotations, I found the following from Herodotus, who was a Greek historian and philosopher, 484-425 B.C. (about 24 hundred years ago!): "The art of medicine in Egypt is thus exercised: one physician is confined to the study and management of one disease; there are of course a great number who practice this art; some attend to the disorders of the eyes, others to those of the head, some take care of the teeth, others are conversant with all diseases of the bowels; whilst many attend to the cure of maladies which are less conspicuous."

Very truly yours,

Ben F. Wyman, M.D.,
State Health Officer

PUBLIC HEALTH NEWS

DR. HAYNE PRESENTED SILVER PITCHER AND TRAY BY COLUMBIA MEDICAL SOCIETY

At the regular scientific meeting of the Columbia Medical Society held in the ballroom of the Columbia Hotel on the evening of January 14th, Dr. James A. Hayne, Director of the Division of Health Education, was presented a silver pitcher and tray in honor of his services to the Society, to organized medicine and to the people of South Carolina.

Dr. Wm. A. Boyd, who made the presentation speech in honor of Dr. Hayne, pointed out that Dr. Hayne came to the State Board of Health in 1911 and served 33 years as State Health Officer before resigning that position in 1944. During Dr. Hayne's administration, he assumed leadership in having compulsory vaccination law enacted, and made possible free distribution of typhoid vaccine, diphtheria antitoxin, smallpox vaccine and anti-meningococcic serum. It was also during his administration that the S. C. Tuberculosis Sanatorium was built. When Dr. Hayne was appointed State Health Officer, the State Board of Health had only two divisions; when he resigned, they had increased to twelve.

In expressing his appreciation for the beautiful award, Dr. Hayne said, "I am proud to have lived long enough to have seen the profession of medicine become a real science." He said it was gratifying to hear "wonderful things said of oneself instead of reading them."

DR. GUYTON DIRECTING DIVISIONS OF CANCER CONTROL AND VD CONTROL

Dr. C. L. Guyton, who received his discharge from the Army Medical Corps in January, resumed his position as Director of the Division of Cancer Control and was also appointed Director of the Division of Venereal Disease Control as of February 1.

Dr. Joe M. Chisolm, who was assigned to the State Board of Health by the USPHS to direct the VD Division during the war emergency, will continue with the Division as Assistant Director pending a new assignment by the USPHS.

Dr. Guyton volunteered for service in the Medical Corps in May, 1942, with the rank of Captain. He held the rank of Lt. Colonel when discharged. His first assignment was at Fort Jackson. Later assignments took him to Michigan, Kansas, New Orleans, and to Carlisle Medical Service School in Pennsylvania.

During the past two and a half years, while he was assigned to the Division of Preventable Medicine

under General Simmons in the Surgeon General's office, Dr. and Mrs. Guyton lived in Alexandria, Va.

DR. H. F. WILSON RETURNS TO DUTY WITH STATE BOARD OF HEALTH

Dr. H. F. Wilson, who recently returned to Columbia following his discharge from the Army, is back on duty with the State Board of Health, from which he obtained a leave of absence in July, 1941 to enter active service as a Major in the Medical Corps, AUS.

Dr. Wilson's first assignment was Fort George G. Meade, Maryland. He was later transferred to the Medical Division, Office of the Chief, Chemical Warfare Service, Washington, D. C. In November 1943 he became director of the Toxicological Research Laboratory, Technical Command, Edgewood Arsenal, Maryland. After a tour of duty of six months at Edgewood he was transferred back to Washington. He attended the School of Military Government at Princeton University and was sent to Columbia Medical Center in New York City for a Refresher Course in tropical diseases. He served overseas for a period of eleven months and participated in the battle of the Philippines and the Okinawan campaign. His last assignment on Okinawa was Port Surgeon for Army Ports, headquarters at Naha.

Dr. Wilson was promoted to the rank of Lt. Colonel in 1942 and became a Full Colonel in January of this year. He wears the following ribbons: American Defense, American Theater, Purple Heart, Asiatic Pacific Theater with 2 battle stars, Philippine Liberation with 1 battle star, and the Victory.

Mrs. Wilson, who lived in Washington, D. C., during Doctor Wilson's overseas service, accompanied him to Columbia.

VD CASES IN SOUTH CAROLINA DROP MORE THAN 30 PER CENT IN 1945

The number of persons requiring treatment for venereal disease in South Carolina dropped from 21,856 in the fiscal year 1943-44 to 14,856 in the fiscal year 1944-45, a decrease of more than 30 per cent.

Dr. Joe M. Chisolm, Director of the Division of Venereal Disease Control, attributes the remarkable decrease in case treatments by the State Board of Health and private physicians to the rigid enforcement of quarantine regulations throughout the State and rules for hospitalization for rapid treatment.

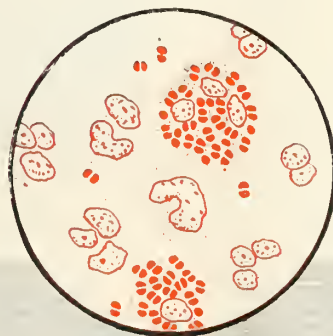
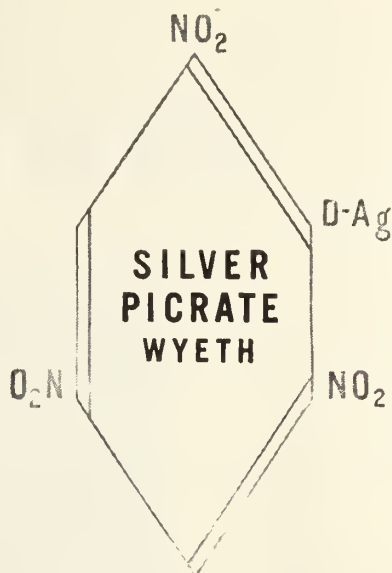
PICRAGOL

TRADE-MARK



PICRAGOL is an effective agent in the treatment of urethritis and vaginitis. Its specific action is especially valuable for the control of trichomoniasis or moniliasis of the vagina and for trichomonas infections of Bartholin's or Skene's glands.

PICRAGOL CRYSTALS, Bottles of 2 grams. • COMPOUND PICRAGOL POWDER, Silver Picrate Wyeth, 1 per cent, in a kaolin base. Packages of six 5 gram vials. • VAGINAL SUPPOSITORIES PICRAGOL, Silver Picrate Wyeth, 0.13 grams, in a boroglyceride-gelatin base. Packages of 12 • VAGINAL SUPPOSITORIES PICRAGOL, for infants, Silver Picrate Wyeth, 65 mg., in a boroglyceride-gelatin base. Packages of 12.



Wyeth

All cases admitted to the public health hospital for rapid treatment during the past year, Dr. Chisolm said, left the hospitals cured, while formerly, under the old system of treatment, many persons being treated for venereal disease were given a few treatments which did not render them non-infectious and were allowed to again circulate in society.

Dr. Chisolm also gave as a reason for the decrease in venereal disease patients the fact that public understanding of the problems involved had created better public support.

Rapid therapy contributed largely to the complete cure of venereal disease in the State, as 63 per cent of those admitted to the public health hospital during 1944-45 were given this treatment.

Incidents decreased in nearly every type of venereal disease, but Dr. Chisolm emphasized that there was more than a 50 per cent drop in syphilis cases alone.

ARMY NEUROPATHOLOGISTS REPORT ON EXAMINATION OF DR. ROBERT LEY'S BRAIN

The brain of Dr. Robert Ley, Nazi leader, which was shipped by air to the United States in November of last year for gross examination and microscopic study by Army pathologists shows "a long-standing degenerative process of the frontal lobes," Major General Norman T. Kirk, Surgeon General of the Army, has announced.

Degeneration in the brain of Dr. Ley, who hanged himself to avoid trial as a war criminal, was sufficient to account for the unusual behavior of the former German labor leader, according to the announcement.

Reports on the results of the neuropathological study of the brain, which was made at the Army Institute of Pathology under the direction of Colonel J. E. Ash, stated that photographs of the brain show considerable thickening of the brain covering over the frontal lobes of both sides. The underlying convolutions as well as some of the blood vessels are hidden from view by this thickening. However, the rest of the brain has a normal appearance, in that it is delicate and transparent.

Slight atrophy is indicated by the prominent condition of the grooves between the convolutions of the frontal lobes, and examination of the frontal lobes under the microscope disclosed a long-standing degenerative process, which in medical parlance is

referred to as a "chronic encephalopathy."

This disease process cannot be ascribed to the airplane accident Dr. Ley suffered in 1917, because the damage is so symmetrical, according to Army pathologists. They also added that there is no evidence of pre-existing meningitis.

Dr. Ley's type of degeneration, the report pointed out, is sometimes seen in those addicted to alcohol, but proof that alcohol is in itself a causative factor is completely lacking. The degeneration is of sufficient duration and degree to have impaired Dr. Ley's mental and emotional faculties and could well account for his alleged aberrations in conduct and feelings, since normally the frontal lobes are requisite for complex types of thinking and for a proper development of the "social sense" and since they exercise a restraint on emotional impulses, the report explained.

The Army Institute of Pathology worked on Dr. Ley's brain here in line with its policy of making studies to supply data for future reference in Army and Veterans Administration problems and as a contribution to medical science in general. The Ley brain will be stored in a preservative so that it will be available for future reference.

In addition to its work in conducting investigation and research on diseases of medico-military importance, the Army Institute of Pathology also furnishes a consultation service for the diagnosis of pathologic tissue for the entire Army and supplies instruction in pathologic anatomy to Medical Department officers.

DEATHS

Dr. Robert Boyd Stith, 60, died at his home in Mullins on February 1. He had been in poor health for several years.

A native of Lamar, Dr. Stith was graduated from the University of Nashville in 1909. He practiced in Lamar for eighteen years before moving to Mullins. A fine physician and a Christian gentleman, Dr. Stith's passing will be mourned by his many friends.

He is survived by his widow, the former Miss Eula Rogers, two sons and one daughter. One of his sons, Dr. R. B. Stith, Jr., is now practicing in Florence.

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AIKEN, SOUTH CAROLINA

South Carolina Medical Association

1945-1946

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The Journal of the South Carolina Medical Association

APRIL, 1946

VOL. XLII, NO. 4

Annual Meeting
Myrtle Beach, S. C.



BOSTON

April 30

May 1 and 2

BACKGROUND

Three Decades of Clinical Experience

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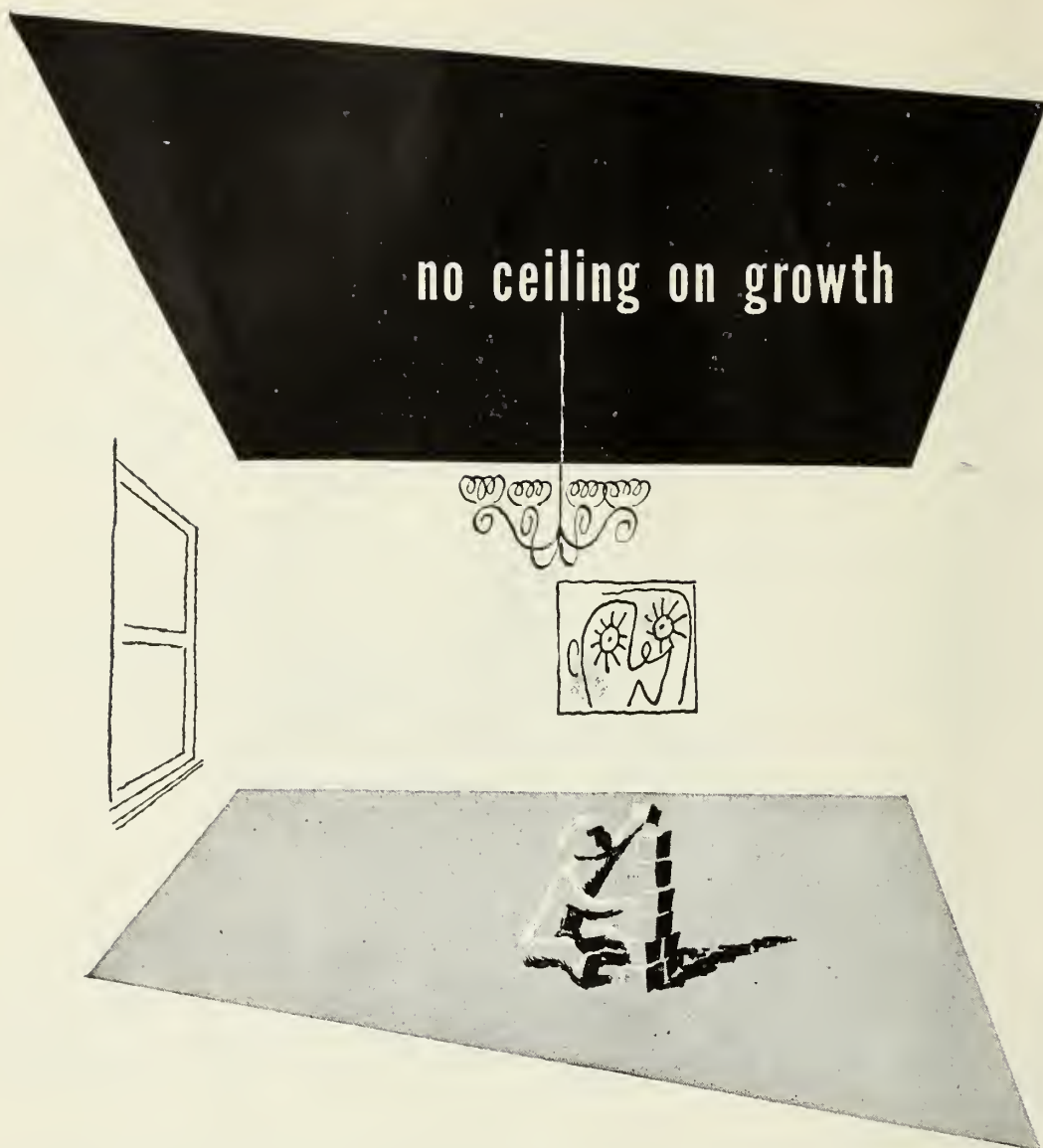
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OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879. Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918.

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

April, 1946

NUMBER 4

Program

House of Delegates

South Carolina Medical Association

2:00 P. M. April 30, 1946

Myrtle Beach, S. C.

Call to order—Dr. W. T. Brockman, President
Report of Credentials Committee
Remarks by the President
Report of Director of Public Relations and Counsel—Mr. M. L. Meadors
Report of the Secretary—Dr. J. P. Price
Report of Council—Dr. R. B. Durham, Chairman
Appointment of Committee on Resolutions
Report of State Board of Health—Dr. W. R. Wallace, Chairman, Executive Committee
Report of Delegate to American Medical Association—Dr. Hugh Smith
Report of Delegates to Rural Health Conference—Dr. W. L. Pressly
Report of State Board of Medical Examiners—Dr. N. B. Heyward, Secretary
Report of Committee on Medical College Expansion Program—Dr. James McLeod, Chairman
Report of Permanent Committee on Hospitals—Dr. Jack Parker, Chairman
Report of Committee on Location of Physicians—Dr. W. L. Pressly, Chairman
Report of Committee for Study of Medical Service Plans—Dr. Hugh Smith, Chairman
Report of the Committee on Scientific Work—Dr. J. D. Guess, Chairman
Report of the Committee on Legislation and Public Policy—Dr. M. Nachman, Chairman
Report of the Committee on Public Health and Instruction—Dr. I. H. Grimbball, Chairman
Report of the Committee on Postwar Planning—Dr. William H. Kelly, Chairman
Report of the Committee on Postgraduate Medical Activities—Dr. W. S. Judy, Chairman
Report of the Committee on Historical Medicine—Dr. J. Warren White, Chairman
New Business

Elections—

President-elect
Vice-President
Secretary
Treasurer
Councilors

2nd District (The term of Dr. R. B. Durham expires this year)
5th District (The term of Dr. Roderick McDonald expires this year)
8th District (The term of Dr. George Truluck expires this year)

Board of Medical Examiners

2nd District (The term of Dr. George R. Wilkinson expires this year)
4th District (The term of Dr. W. R. Tuten expires this year)

Selection of place for 1947 Annual Session

Adjournment

Scientific Assembly

Preliminary Program

South Carolina Medical Association

Ocean Forest Hotel, Myrtle Beach

April 30 - May 2, 1946

TUESDAY, APRIL 30

- 10:00 A. M. Meeting of the Council
2:00 P. M. House of Delegates Convenes

WEDNESDAY, MAY 1

- 9:30 A. M. Call to Order
Address of Welcome: Dr. M. Nachman, President, Greenville County Medical Society
Address of Welcome: Dr. J. Archie Sasser, Conway
Response: Dr. E. M. Dibble, Vice-President, Dillon
- 10:00 A. M. Paper No. 1
Certain New Anti-histamin Drugs, Dr. Wm. H. Kelly, Charleston
- 10:30 A. M. Special Order
President's Address—Dr. W. T. Brockman, Greenville
Memorial Service, led by Dr. Jack D. Parker, Chairman, Memorial Committee, Greenville
- 11:00 A. M. Paper No. 2
Meningococcemia, by Dr. John F. Rainey, Anderson
- 11:30 A. M. Paper No. 3
The Application of Sympathetic Nerve Interruption to Organic Obstructive Vascular Disease, by Dr. Horace G. Smithy, Charleston
- 12:00 M. Special Order
Address by Dr. Richard B. Cattel, Lahey Clinic, Boston—Subject: Gall Bladder Disease
- 1:00 P. M. Luncheon Recess
- 1:15 P. M. Alumni Luncheon
- 2:30 P. M. Paper No. 4
The Treatment of Hemothorax and Its Complications in Thoracic Injuries, by Dr. Edward F. Parker, Charleston
- 3:00 P. M. Paper No. 5
The Management of Ureteral Calculi, by Dr. Lawrence P. Thackston, Orangeburg
- 3:30 P. M. Paper No. 6
Management of Thyroidectomy Incisions, by Dr. Furman Wallace, Spartanburg
- 4:00 P. M. Special Order
Address by Dr. Louis J. Hirshman, Detroit—Subject: Proctology in Childhood
- 5:00 P. M. Adjournment
- 7:00 P. M. Reception and Banquet (Ladies invited) Address by Dr. James McLeod, President-Elect, Florence

THURSDAY, MAY 2

Second Scientific Session

- 10:00 A. M. Paper No. 7
Kerosene Poisoning — Clinical, Pathological and Experimental Consideration, by Drs. J. I. Waring, H. R. Pratt-Thomas and J. A. Richardson, Charleston
- 10:30 A. M. Paper No. 8
Indications for Interruption of Pregnancy and Puerperal Sterilization, by Dr. D. Strother Pope, Columbia
- 11:00 A. M. Paper No. 9
Practical Suggestions for the Care of Obstetrical Patients, by Dr. Arthur L. Rivers, Charleston
- 11:30 A. M. Special Order
Address by Dr. F. Bayard Carter, Professor of Obstetrics and Gynecology, Duke University.
Subject: Premature Detachment of the Placenta. Round Table, led by Dr. Carter
- 1:00 P. M. Adjournment, Sine Die

On Monday, April 29, at the Ocean Forest Hotel, the Greenville County Medical Society will hold a joint meeting with the Pee Dee Medical Association. The meeting will be preceded by a reception at 7:00 P. M. At 7:30 P. M. a Dutch dinner will be served.

The speaker of the evening will be Dr. Louis J. Hirschman of Detroit. His subject will be, "A Proctologist's Message to the General Practitioner."

Following the address there will be presented a discussion of political medicine, arguments for and against. The discussion will be in the form of a trial court.

All members of the South Carolina Medical Association are cordially invited to be present.

On Tuesday evening, April 30, at 7:00 P. M. the annual banquet of the South Carolina Pediatric Society will be held. There will be a fine program which will be prepared and presented by the department of pediatrics of the Medical College of the State of South Carolina.

All members of the South Carolina Medical Association are invited to be present.

GUEST SPEAKERS

DR. FRANCIS BAYARD CARTER

The guest speaker on obstetrics will be Dr. Francis Bayard Carter. Dr. Carter is professor of obstetrics and gynecology at Duke University medical school and chief of the division of obstetrics and gynecology, Duke University Hospital.

Dr. Carter received his medical degree from Johns Hopkins in 1925. He organized his department when the Duke Medical school was opened. He is a diplomate of the American Board of Gynecology and Obstetrics, and is presently an examiner for the Board. He is a fellow of the South Atlantic Association of Obstetricians and Gynecologists and of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons.

He is a man of pleasing personality, an interesting speaker and an exceptional teacher.

DR. RICHARD B. CATTELL

Dr. Cattell, guest speaker in surgery for the State meeting, is known and admired by many South Carolina doctors. Surgical conditions of the gall bladder has long held peculiar interest for him. It is on some phase of this problem that he will speak.

Dr. Cattell is chief surgeon at the Lahey Clinic in Boston. He served there as fellow in surgery from 1927 to 1929, after having received his M.D. Degree from Harvard in 1925. While a fellow, his ability was recognized and he was retained on the staff of the clinic.

He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, a member of the American Association for Study of

Goiter. He is also a member of the American Surgical Association and of the New England Surgical Society.

DR. LOUIS J. HIRSCHMAN

Our guest speaker in proctology is a pioneer of unusual ability and one upon whom many honors have been heaped. These have been well earned by a long life devoted to teaching and writing in a field of surgery which he helped make respectable and worthy of a place as a true specialty in medicine.

Who's Who uses half a column to list his accomplishments and honors. He has been professor and head of the department of proctology at the Detroit College of Medicine (now Wayne University) since 1909. For 34 years he was chief proctologist at Harper Hospital and proctologist or consulting proctologist at numerous other Detroit hospitals. He is extramural lecturer in post-graduate medicine, University of Michigan.

He is a founding fellow of the American College of Surgeons, was vice-president of the American Medical Association, 1930-31 and president of the Michigan Medical Society, 1928-29. He is a past president of the American Proctologic Society, and was one of the organizers of the American Board of Proctology. He was chairman of the certifying committee of the American Board of Surgery, 1940-45.

He has written several books on ano-rectal diseases, and has published innumerable articles.

He has done us a distinct honor to attend our meeting and to be so generous with his time and talents.

EXHIBITORS

(The following firms will exhibit at the annual session.)

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Borden Company
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Doho Chemical Corporation
Eli Lilly Company
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G. D. Searle
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Philip Morris Company
Picker X-ray Corporation
Powers & Anderson Company

Reed and Carnrick
Schering Corporation
Sharp & Dohme
Tablerock Laboratories

Van Pelt & Brown
White Laboratories
Winchester Surgical Supply Company

Exchange Department

(Each month there come to the editorial offices of this Journal more than two score state or sectional medical journals published in the various parts of this nation. Many of these journals contain articles and editorials which would be of real interest to the members of our Association.

As space permits, we will publish selected articles or editorials or comments or abstracts of these in this department of our Journal.)

FROM ROCKY MOUNTAIN MEDICAL JOURNAL—FEBRUARY, 1946

Observations on the Etiology, Pathology, and Symptomatology of Poliomyelitis, with

Special Consideration of Dehydration Treatment of Poliomyelitis

T. E. ROBINSON, M.D., SALT LAKE CITY, UTAH

In preface may I say that poliomyelitis is one disease that has, with a few exceptions, defied study in any large or even small series of cases by one observer. The disease has by rule been spotty in areas of distribution and largely because of this fact have I found the courage to present my observations and deductions in a small group of cases in the hope that it may contribute in some small way to the solution of a problem which frequently becomes a disaster of great magnitude in the life of the one afflicted. I do not profess that any of these observations or the method of treatment are new or that someone else has not tried or reported them.

My first thoughts in using dehydration in the treatment of acute poliomyelitis came several years ago, but my first opportunity to use it presented itself in 1940, at which time I had two cases in the Salt Lake General Hospital which made rapid and remarkable recoveries on this treatment.

The first case was that of a boy about 4 years old, who in spite of giving aspirin and paregoric in moderately heavy doses during the night, kept crying with pains in his legs until the mother called me again at four o'clock in the morning to come and see him. Upon examination he had typical spasm in the posterior groups of leg muscles and upon attempting to extend the legs, the pain in both legs and in the lumbar areas was severe. He had marked diminution in his patellar reflexes and loss of the Achilles reflexes. The cremasteric and abdominal reflexes were intact. A spinal puncture revealed the fluid to be under normal pressure but the cells were increased to about 60 with lymphocytes predominating. He was given 50 c.c. of 50 per cent sucrose solution intravenously and within forty minutes after this treatment the

youngster stopped complaining of pains and there was considerable decrease in his spasm. He had no other sedation. His general fluid intake by mouth was limited to 800 c.c. daily and he was given daily infusions of 50 c.c. of 50 per cent sucrose. He was discharged from the hospital in five days feeling well and with his reflexes normal. Now the most interesting thing about this boy was that I was called by the mother about twelve hours after he got home and was told that he was complaining of pain in his legs again. I inquired about fluid intake and found he had taken an estimated 1,500 c.c. in the twelve hours. We took fluids away completely and in a few hours his pain again disappeared. The mother also observed that not infrequently while the child was drinking fluids that he would strangle from getting the fluids into the naso-pharynx. This had not been noted in the hospital but I felt that it must be due to a mild involvement of his pharyngeal and palatine muscles and was further proof as to the validity of our diagnosis. The general fluid intake was kept down for three weeks in order to give time for restitution to normality of the cells in the spinal cord, which had been injured by the pathological processes of the disease. He had no further symptoms.

About ten days later I saw a girl 18 years old complaining of severe headache and severe pains in the lower dorsal spine. She had a temperature of nearly 104, and had definite spasm in her neck and dorsal spinous muscles. Flexion of the head on the chest caused rather severe pain in her neck and back. She was hospitalized and spinal fluid was not under increased tension but showed over 200 cells with the large majority lymphocytes. Her mid-abdominal reflexes were lost but all other reflexes were intact. She was given 50 c.c. of 50 per cent sucrose intravenously and here again her severe headache and back pain had almost completely subsided within forty minutes and peculiarly enough the temperature responded rapidly and did not seem to recur. I will make some observations about this later. This case was restricted to 1,000 c.c. of fluids by mouth daily and she was given 10,000 units of thiamin chloride daily empirically. She was discharged from the hospital in five days apparently well but she was kept on a restricted fluid intake for a few weeks. She was given daily intravenous injections of 50 c.c. of 50 per cent sucrose while in the hospital.

In 1943 we had an epidemic of poliomyelitis in Utah and it was my privilege to see a considerable number of these cases. Many of them were of the abortive type, but about fifteen cases were definite and severe enough that I felt a diagnosis was justifiable. One boy 9 years old, the son of a graduate nurse, was quite ill. I was called about thirty-six

hours after onset of symptoms and when I saw the boy he had a temperature of 105, was delirious, and presented marked spasm of the muscles of the lower extremities, spasm of the muscles of the back and neck, and either marked diminution of or complete loss of his patellar, Achilles, cremasteric, abdominal, and biceps reflexes. There was no increase in either cells or pressure on spinal puncture. I put him on immediate dehydration therapy in spite of his high fever and, strangely enough, the fever and other severe symptoms had improved beyond all expectation in forty-eight hours. Within ten days the reflexes had returned to normal. His mother, being a nurse, was anxious to use the Kenny packs, and this treatment was instituted after the patient was well on the road to recovery.

I treated several of these cases without the use of the Kenny packs and it was really gratifying to see the response in relief of pain and in the relief of spasm in all cases except one. In this case, a girl, 14, the symptoms had been present for a week before I saw her and the marked spasm which she had in her posterior group of leg muscles and spasm in her back muscles were not much influenced by the sucrose intravenously, and it was ten days before she really began to respond and her response was slower than any case I had. I will make an observation on this later to explain why, in my judgment, she was slow to respond. Incidentally, this case was complete in her recovery in three months' time.

One other interesting case was in a young girl 15 years old, who had a fever, a mild sore throat, and a backache. I was just leaving on a vacation for a few days and told the father if the girl was not better in twenty-four hours he had better call another physician. I returned eight days later and found they had not seen a physician. I went to see her and found she had a rather extensive paralysis. She could not raise either leg off the bed nor could she raise her head off the pillow. Her arms were definitely weak, especially in the flexor group. Her leg and lower abdominal reflexes were absent. She had a marked degree of spasm in her posterior leg muscles, and in her back muscles. I gave the patient 100 c.c. of 50 per cent sucrose intravenously and told the father to see if he could demonstrate any change in her ability to first flex the thigh on the abdomen and then extend the leg on the thigh. The next day his comment was, "Doctor, it was miraculous." He had noted a big change within thirty minutes after the injection. Some of this improvement was still manifest twenty-four hours after the treatment. She was kept on sucrose dehydration for ten days and within a week she could raise either leg three to six inches off the bed and could raise her head off the pillow. Her fluid intake by mouth was kept down to 1,000 c.c. for the next three months and with graduated exercise this little girl returned to school in less than four months from the time she was taken ill. This seemed quite remarkable to me in light of her exten-

sive involvement.

In another case, the diagnosis was obscured until on the third day, when the patient developed a diplopia and a paralysis of his left lid muscles so he could not close his eye. Twenty-four hours after giving sucrose there was slight improvement and within three days all symptoms had disappeared.

The other cases treated have had varying degrees of spasm, loss of reflexes and other symptoms. In the interest of conservation of time, I will just state that each one has recovered rapidly and completely. I have not had one case with residual sequelae, such as paralysis, spasm or deformity.

In no case where treatment was instituted early have the symptoms become worse but have seemingly begun to improve almost immediately.

My limited experience has impressed me that poliomyelitis is not a very toxic disease and that only by reason of the location of its pathology does it become a major problem in the medical world. I feel certain that during epidemics of this disease there are many, many more cases of such minute import as never to be seen by the medical profession than there are cases that come to the spastic or paralytic stages. Even in many cases of paralysis the child has never been toxic. I feel that the cases who get high fevers do so because the thermal center of the brain has been involved and not because of the toxic products of the disease itself. And this involvement, in the thermal center, produces fever largely in a mechanical way—by pressure from edema. Relieve this edema by the only logical means at our command today—by general dehydration, and the fever disappears. If this reasoning is right, then we have surely caused many of these cases under our care an aggravation of his troubles by forcing fluids. Fever in any degree seems only to accompany those cases who have symptoms referable to the high centers—and not always then, because the one boy with diplopia ran a very low temperature. Thus it seems quite logical to believe that only as the thermal center is almost directly involved does the fever become a great problem.

In the same way the pain in these cases is produced in a mechanical way—by pressure on the posterior root segments which are involved by reason of the acute edema and swelling that occurs in the anterior horn cells, where pathologically the greatest damage seems to be done. If you relieve the swelling here again you relieve the pain as well as stop the degenerative process which is occurring in the anterior horn group from the acutely edematous process which has deprived this area of normal lymphatic and vascular physiology. Similarly the contiguous areas of the spinal cord are involved to a lesser degree by the edematous process or by mechanical encroachment due to the nearby swelling and thus we frequently see the opposing group of muscles thrown into spasm, because of increased nerve stimuli being sent out

over the efferent nerve routes to this opposing group of muscles. To me this is anatomically and logically sound as the explanation that there is both paralysis and spasm present to explain findings rather than just spasm as some propose. I wish to call attention also to the fact that many cases are not so acutely congested in the anterior horn region as to produce paralysis but are sufficiently congested to produce spasm. I feel certain that Sister Kenny has definitely contributed something to these children but I believe that her results, at least in early cases, are largely based on dehydration from the packs and that if my reasoning is correct there is a much shorter and easier way of accomplishing the desired results. Except for the two cases I treated in 1940, none of my cases has been hospitalized and they do not present very difficult problems for home treatment. This, contrasted to institutional and Kenny method treatments, constitutes a major innovation.

I would like also to state that anatomically I cannot agree fully with her muscle re-education theory. I am firmly convinced that it is a question of educating muscles in a large part to respond as they do not normally respond in daily life. We do not use many of the muscles while lying in bed that we use when we are up and about, and to make muscles and groups of muscles respond while lying down that do not through habit respond while we are lying down is no easy matter even for an adult. To the scientific mind, who would like to prove this point, I suggest that he lie down and under direct volition contract the various flexor and extensor groups of first the leg, then the thigh, then the forearm, then the arm, shoulder and back, now the gluteal groups. Do this without moving the bone framework. You will find that it takes lots of practice and I do not believe that the problem of muscle contraction is much other than this kind of education in the polio case.

I am not certain just why the one case I have mentioned was so slow in relieving of her muscle spasm. Maybe I did not pursue dehydration treatment far enough—I never gave more than 50 c.c. of 50 per cent sucrose daily. Possibly more would have helped. I think this field should be investigated further. I do feel quite certain, however, that the destruction or impairment in the spinal cord or higher centers will require variable periods of time to repair and assume their normal lymphatic and vascular and other physiological processes dependent upon the amount of original injury to these tissues by the original invasion of the polio virus. And on this principle I feel sure that restriction of fluids must be maintained for variable periods during the repair process and that the earlier dehydration is instituted in the treatment, the shorter will be the period necessary for limitation of fluids. I am sure I need not say that if dehydration as a principle is correct in the treatment of poliomyelitis, then we have probably increased the severity of the disease and even caused

death in many children by adopting the otherwise good rule of forcing fluids in infections.

The more I see of this disease and the more I study the pathology and attempt to correlate it with physiological deductions, the more convinced I become that any case surviving the invasive stage of the disease, which in my experience lasts from forty-eight hours to as long as eight days, need have very little if any residual paralysis longer than three to four months, if dehydration is adequately and properly carried out.

I wish to caution that it may take several days to two weeks of daily sucrose injections to induce what I choose to term a reversal of cellular fluid exchange so as to cause the fluids to start leaving the damaged cells, but once this is started then recovery is rapid and the sucrose may be discontinued and the patient kept only in a state of relative dehydration by limitation of total fluid intake to where the first A.M. specimen of urine has a specific gravity of 1.025 to 1.030. In other words, I doubt seriously that much irrecoverable destruction of nerve tissue occurs in the first week to ten days and that the irrecoverable destruction which occurs does so after the invasive stage of the disease is over and does so on the basis of pressure necrosis. If we relieve this pressure we prevent such necrosis and the cells recover very rapidly.

It is well to remember that this treatment is directed at the effects of the disease and not at the cause and, therefore, necessarily is not the answer to the control of the disease but only to the control of its effects. However, in its past and present state of virulence, at least, these effects constitute its major importance clinically.

Generalized muscle spasm seems usually to occur several days after the initial onset of the disease. I believe that this stage of general muscle spasm will never be reached if dehydration therapy is started within the first two or three days of the disease. It seems there is a rather definite tendency for most of the mildly severe untreated cases of polio to drift toward this somewhat generalized spastic state and this spasm seems much more frequent, than not, to be limited to the posterior groups of muscles. That is, the posterior leg and thigh groups, the posterior groups of spinous muscles and the posterior cervical groups of muscles. Why this tendency to spasm over such a wide area when the original invasion of the virus seems somewhat spotty and segmental presents a very intriguing problem.

Thus it seems that there may be more than edema of the spinal cord for the late spasms and although response may be best with multiple approaches in therapy, it seems consistent with good logic that generalized dehydration should be kept up for several months on the cases with a great deal of spasm in order that the pressure on the damaged segmented areas of the cord might be relieved until these areas

have had ample time to re-establish the best lymphatic and vascular balance. This too in turn would permit normal restitution of damaged (not destroyed) nerve cells.

I would like to comment in passing that along with the other actions, some of the relief of muscle spasm from prostigmine may be from its dehydrative action. Most children after being given prostigmine have rather copious bowel movements and lose lots of intestinal fluids and this creates a general dehydrative influence.

In summary then the following observations and deductions have been considered:

1. That poliomyelitis is usually not a toxic disease.
2. That it produces serious injury and becomes a major medical problem only when certain vital areas

are involved.

3. It is my belief that pressure from edema in these vital areas produces the spasm, the pain, the paralysis, and that most of those with high temperatures have them because the thermal center is involved.

4. That because of the pressure from edema that general dehydration presents, at present, the logical early treatment for relief of this pressure and that similarly the fever will respond to the same treatment and that forcing liquids is contraindicated because of their potential of increasing both the morbidity and the mortality rate.

5. The general limitation of fluids must be persisted in for from a few weeks to several months depending on the extent of the original damage to the cellular structure of the spinal cord.

STATEMENT ISSUED BY S. C. STATE BOARD OF HEALTH

The South Carolina State Board of Health, with financial assistance from the State, the various counties of the State, and the Federal Government, is now carrying on a wide and extensive health program. The funds provided by the Federal Government are of considerable amount, and hence, of great importance. Various bureaus or agencies of the Federal Government provide financial assistance in many of our programs: maternal and child health, particularly as it affects the treatment of soldiers' wives and infants; venereal diseases, crippled children, tuberculosis, malaria, typhus, and general health.

The Executive Committee of the South Carolina State Board of Health feels that a public statement clarifying its position with regard to pending legislation in Washington affecting public health and the practice of medicine is timely and will be helpful to the community.

The Committee approves that portion of the proposed legislation providing funds for the erection of hospitals, health centers and diagnostic institutions where the need for such establishments has been clearly shown. Similarly it endorses those portions of the program dealing with the expansion of public health activities in connection with services for crippled children, and control of venereal disease and tuberculosis. It favors continuation of federal assistance in maternal and infant care for the indigent.

It supports the move to foster medical teaching and research by federal funds which shall in no way

obligate the recipients. The measures proposed to provide sickness and disability benefits are wholly commendable as are those which contemplate the allotment of federal funds to the various states to enable these states to provide medical care for indigent persons.

The Committee is opposed to any federal control of medicine and its related branches which will permit, directly or indirectly, domination of medical or dental service by a government bureau. Because the Committee feels that federal compulsory health insurance now under consideration in Congress will inevitably bring this about, it hereby expresses its unqualified disapproval of that portion of the plan as envisioned in both the message of President Truman and in Title 11 of the current version of the Wagner-Murray-Dingle Bill.

While the Committee is aware of the desirability of easing the burden of expense of illness and broadening the benefits of preventive medicine, it believes these ends can be reached more effectively by evolutionary than revolutionary methods. The rapid growth of voluntary hospital and medical service plans, such as the Blue Cross, is indisputable evidence of healthy activity of this evolutionary trend. Furthermore, it feels that wholly inadequate evidence has been advanced that compulsory health insurance will either assure better care at a lowered cost to the American people, or would better serve the interests of public health.

South Carolina Medical Association

1945-1946

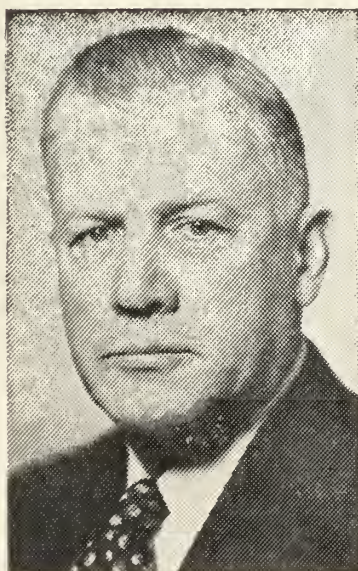
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The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Office of Publication: (In care of the Editor)

Florence, S. C.

Subscription Price

\$3.00 per Year

APRIL, 1946

Members of the S. C. Medical Association

Gentlemen:

It was an honor and pleasure to the Greenville County Medical Society when the House of Delegates voted to hold their 1946 annual meeting in Greenville. We immediately appointed committees and set about to arrange for an outstanding meeting because we realize that the first meeting after the war necessarily must be a great event. At the time we extended the invitation we were assured of adequate hotel accommodations, however, recently we were informed that the hotel facilities of Greenville are so crowded that it would be impossible for us to assure all our guests of hotel reservations and it was decided by the members of our society that unless we could have everything in perfect order that it would be better not to attempt to hold our annual meeting in Greenville; so under these conditions the State President, Dr. Tom Brockman, and the members of the Council made the arrangements to have the meeting held in the Ocean Forest Hotel at Myrtle Beach.

Since we, the Greenville County Medical Society, have progressed so far with our plans, the Council has consented to let us continue as the host society.

It was also our plan that if the meeting was to be held in Greenville to have our County Medical Society meeting on Monday, April 29, the night which is before the Council and House of Delegates Meeting so that any of the visiting physicians could join us in this meeting. We are now planning to have this same meeting and have as our co-host the Pee Dee Medical Society and we wish to invite every member of the State Medical Association to be with us.

Kindest personal regards.

Sincerely,

Mordecai Nachman, M.D., Pres.

Greenville Medical Society.

THE ANNUAL MEETING

We predict that the attendance at our coming annual meeting which is to be held at Myrtle Beach will be the largest in the history of our Association. And we base our prediction upon four beliefs.

First, this is the first full schedule meeting we have had in four years. Physicians have missed these annual gatherings and will be anxious to get together once more with friends whom they have not seen since the first year of the war.

Secondly, those of our number who have been discharged from military service are anxious to get back into the normal swing of medical affairs and to meet friends once more. They will be coming to Myrtle Beach and how welcome they will be!

In the third place, the grind of wartime work has tired many physicians and they will be looking for the slightest opportunity to get away from the stethoscope and scalpel for a few days and to enjoy a recreation without the disturbing and penetrating ringing of the telephone.

And finally, Myrtle Beach is noted as a real playground—and old or young, doctors still like to play.

Yes, we predict that this will be the largest meeting in our ninety-eight years of history—and we also predict that those physicians who do not come will be the losers.

GREENVILLE HOSPITALITY

It was with keen regret that a committee from the Greenville Medical Society waited upon Council with the information that hotel facilities in that town were insufficient for the annual meeting of the Association. Plans had been made for a gala gathering and the physicians of Greenville were making every effort to make the meeting a real success—when the news came to them from hotel managers. The lull in demand for hotel space which had been anticipated for winter and spring had not materialized and the hotels found themselves more crowded than ever. It was a situation over which no one had control and for which no one was to blame.



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THE OCEAN FOREST HOTEL, MYRTLE BEACH, SOUTH CAROLINA
OPEN THE YEAR 'ROUND

Upon the motion of a Greenville physician, Council decided to have the meeting at Myrtle Beach. But—and here is the amazing part of the story—the Greenville County Society insisted upon retaining their responsibilities as hosts. Under the leadership of their President, Dr. M. Nachman, they planned to continue their work toward making the meeting the best possible.

For this gracious gesture and for the work which the members are doing, The Journal wishes to express to the members of the Greenville County Medical Society sincere thanks.

MYRLTE BEACH

Except for the fact that it is located on one edge of the state, Myrtle Beach is a "natural" for holding our annual session. There one escapes the rush and bustle of the city with its multitude of interruptions and noises. There one finds himself and his friends set apart from the rest of the world. There one can enjoy the roar of the waves, the breezes which come from the ocean, and the feel of sand between one's toes. There one can sit quietly with his friend and talk of times that were or of things to come.

Under the leadership of Mr. W. W. Myers, the manager, the Ocean Forest Hotel is preparing for the influx of doctors—and no one could be more anxious to make the meeting a success than is the hotel management.

Called upon to help when it became apparent that the hotels in Greenville could not take care of the crowd this year, Mr. Myers met with Council and offered his services and those of his hotel. In subsequent meetings with committees and representatives of the Association, every effort was made to see

that the wishes of the Association were met and that nothing should be left undone which would help to make the meeting better. The members of the Association appreciate this graciousness and The Journal wishes to thank Mr. Myers and his corps of workers for what they have done.

OUR LEADERS

Once again, in annual session, we will be called upon to elect our leaders for the coming year.

With the difficult problems which we will be facing in the days ahead we will need leaders with vision, with courage, and with a willingness to work. Our Association is beginning to make itself felt in national medical circles. We need leaders who can speak for us upon the national platform. More and more, national and state governments are planning legislation which will affect the medical welfare of our people. We need leaders who can counsel with the legislative leaders and see to it that the legislation which is passed is for the best interest of our citizens.

On April 30th we will choose those who shall lead up for the coming year—may we choose wisely and well.

OUR GUEST SPEAKERS

Our able President, Dr. Tom Brockman, has secured three outstanding guests to speak to us at Myrtle Beach. Dr. F. B. Carter of Duke, Dr. Richard B. Cattell of the Lahey Clinic, and Dr. Louis J. Hirschman of Detroit are all men whom we know by reputation is not by actual contact. Each of these men is a recognized leader in his specialty and each will bring information and ideas which should be of value to all.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

COUNCIL STATES POSITION ON PENDING BILL

The press of South Carolina on Sunday, March 10, carried the following formal statement which had been approved and adopted by the Council of the South Carolina Medical Association at a meeting in Columbia a week before:

"The South Carolina Medical Association, through its Council, the executive committee of the organization, has issued the following statement relative to the National Health Bill now pending in Congress, public hearings on which are scheduled to commence on March 18th, before the Senate Committee on Education and Labor:

"The South Carolina Medical Association is vigorously opposed to the pending bill, the third Wagner-Murray-Dingell Bill, which attempts to set up a na-

tional system for the administration of medical care, administered and controlled by government, and financed through taxation. Leaving aside entirely the wishes of the physicians, we are convinced that the proposed legislation and all similar efforts advanced so far, are inimical to the best interests of the public and to the welfare of the nation as a whole, especially for these reasons:

(1) The cost of the system cannot possibly be reckoned. Non-medical authoritative sources have estimated that the amount would be approximately \$4,000,000,000 annually, and require 300,000 additional government employees. At a time when the taxpayers are struggling under the greatest national debt in history, and facing the necessity and obligation of the increasing cost of caring for the veterans,

the government can ill afford to assume this additional burden.

(2) The passage of this bill, we believe, would be the beginning of complete socialization of American economy. Once medicine is socialized and politically controlled, similar action with respect to industry and business generally would be an easy step. Some of the highest authorities on American business and finance, state and national, have within the past few days in public utterances, called attention to the rapid trend toward world socialism and called upon the intelligent leadership of America for militant effort in the other direction, if our present economy is to be maintained. The Wagner-Murray-Dingell bills represent one of the most far-reaching and drastic steps thus far attempted toward socialism in the United States.

(3) The system proposed would prohibit free selection of physician by patient, and tend to lower the high standards of medical service built up throughout the years under our present system. Under the pending bill, the Surgeon General of the United States Public Health Service would have the right to limit the number of patients which any physician might serve. Obviously, the lists of some doctors would be immediately filled and closed, and subsequent applicants for medical service would be forced to accept services of physicians not of their choice. The incentive for the highest type of scientific achievement by the profession would disappear through the removal of the element of personal confidence as the basis of the physician-patient relationship.

"In the past few years, the people have had sufficient experience with government regulation and bureaucratic control to realize that however necessary such a system may be as a war measure, it is expensive, inefficient, unsatisfactory and incompatible with the American temperament."

PLANS UNDERWAY FOR VETERANS' CARE

In line with the action being taken in a number of other states, the officers of the South Carolina Medical Association are giving serious thought and making plans toward working out an agreement with the Veterans' Administration for the handling of outpatient medical care. The examination and treatment of veterans under present regulations may be furnished by The Veterans' Administration through civilian doctors and, in some cases, hospital treatment is rendered in non-government, hospitals. Naturally, all such treatment and medical care, the expense of which is paid by the government, is subject to definite rules and regulations. This is as it should be. Accordingly, the Veterans' Administration has adopted the policy of entering into agreement with organizations of physicians themselves, or organizations connected with the rendering of medical and hospital care, whereby uniform

methods of dealing with the problem and uniform fee schedules are set up and made effective in the area covered by the organization with which the agreement is made.

Dr. Tom Brockman, President of the state association, has been outstanding in leadership in this field in South Carolina. He has given much thought and study to the problem, and according to our information the Greenville Medical Society was the first in the state to take active steps toward effectuating such a program.

The matter was brought to the attention of Council at its meeting in Columbia on March 3; the steps already taken by the Greenville Society were pointed out and at the suggestion of Dr. Brockman, Council authorized immediate action on behalf of the state association toward working out an agreement with the Veterans' Administration.

Pursuant to the action of Council, intensive study is being given to the agreements already entered into by various groups with the Veterans' Administration, and the fee schedules adopted thereunder. Of particular interest in this connection is the agreement affecting the State of Kansas, where the state medical association is the organized body with which the Veterans' Administration has entered into agreement. In some states, notably California and Michigan, the agreements have been made with the organizations administering medical service plans.

As soon as possible the matter will be taken up personally with officials of the Veterans' Administration in Washington, for the purpose of working out tentative provisions for an agreement for submission to Council and the House of Delegates of the South Carolina Medical Association.

HIGHLIGHTS OF THE NATIONAL HEALTH BILL OF 1945

ORIGIN AND HISTORY — This is the third in a series of bills introduced in Congress by the same authors, Senators Wagner and Murray, and Mr. Dingell in the House of Representatives. The original Wagner-Murray-Dingell Bill was introduced in 1944, referred to committee, and because of the unfavorable reaction which resulted, received no further attention. The bill was reintroduced in the House in the early part of 1945 after the new Congress convened. On May 24, 1945, the second bill (S 1050), designated "Social Security Amendments of 1945", was introduced simultaneously in the Senate and House of Representatives and referred to committees. The present bill was introduced on November 19, 1945, immediately following the delivery to Congress of the President's message advocating a National Health Program. The present measure, therefore, comes with the full blessing and support of the White House. This has not been true of the former measures.

The bill (S 1606) was referred to the Committee on Education and Labor in the Senate and to the Com-

mittee on Interstate and Foreign Commerce in the House.

MEDICAL BENEFITS PROVIDED — The bill undertakes to provide, through a system administered and controlled by the government, and supported by public funds, medical and dental services (general and specialized), home-nursing, laboratory and hospitalization benefits.

Any physician, dentist or nurse legally qualified by a state, would be qualified to furnish services.

Any individual entitled to receive the benefits would select the physician, dentist or nurse of his choice for general services, from a panel of those practitioners in each community who had agreed to work under the terms of the measure.

Specialists and consultants would be only those so designated by the Surgeon General of the U. S. Public Health Service, according to standards to be prescribed. Such service could be obtained only on the advice of the general practitioner or a specialist or consultant already attending the individual, and on approval by a medical administrative officer appointed by the Surgeon General.

The names of physicians who agree to furnish services in each community would be published and made known to the individuals in that community by the Surgeon General. The Surgeon General would have the right to limit the potential patients of any practitioner, and these limits "may be nationally uniform or may be adapted to take account of relevant factors." (In this way distribution of patients among all doctors, regardless of qualifications, experience or ability, could be made, and on the basis of political consideration, personal favoritism or any other.) Thus, the deadening influence of the hand of government in the effort to equalize every citizen regardless of initiative, industry, personal inclinations or what not, would be applied in the most vital phase of human life, the preservation of health.

While under the terms of the measure the citizen would have the right to select the physician of his choice, through the limitation power given to the Surgeon General and referred to in the preceding paragraph, the number of patients of the best known, most able physicians, obviously would be promptly filled and the lists closed, so that individuals in the future, seeking the same high class services of these physicians, able to pay for the same from their own funds, and accustomed to such services under our present system, would be denied the right to be treated by the physician of their choice, required to accept the services of those whom they did not prefer or were less qualified, or whom they simply did not want for personal reasons or otherwise. The expression "freedom of choice of physician by patient" which is supposed to be guaranteed by the bill, could easily become a hollow mockery.

Nursing benefits would be available only on the advice of attending physicians or when approved by medical officers designated by the Surgeon General.

Hospitalization benefits would be available only in institutions approved by the Surgeon General in accordance with standards to be prescribed. (It should be noted that the bill in its present form does provide, however, that the Surgeon General shall exercise no supervision or control over a hospital which is not operated by the United States.)

In addition to the foregoing, the bill also provides for the furnishing of maternal and infant care to every mother and her child or children to the age of one year, at government expense, regardless of need or financial condition. In this broad expansion of the EMIC Program, instituted and cooperated in by the physicians as a war measure, all effort to provide assistance because of need, appears to have been abandoned, and any prospective mother in the United States would be entitled to receive from the government prenatal, post-natal and obstetrical care, and service to her child during the first year of its life.

The bill also provides for grants to states to be used in the treatment of social diseases and for the medical care of needy persons.

COST AND FINANCING — Contrary to the method followed in the previous bills, S 1606 makes no attempt to provide through taxation for the support of the program. The omission is obviously bait to catch the unwary. The original bill provided for a levy of 6% of the pay of the employee, to be deducted from his wages like the present Social Security Tax, and to be matched by a like amount to be paid by the employer. The second bill (Social Security Amendments of 1945) attempted to soften the effect by reducing the tax from 6% to 4%. The present bill eliminates the tax altogether. It provides only the benefits. It does not attempt to count the cost. That is left for future disposition as the Congress may decide. Of course, the cost will have to be met, and after the measure has become law, the necessary taxes will have to be provided in another measure. Presumably this would be on the same basis heretofore proposed and collected like the Social Security tax. But whatever the form, the amount would have to be supplied through funds in the United States Treasury placed there by taxation.

The bill authorizes the appropriation for each fiscal year of a sum sufficient for all necessary expenses in carrying out the duties imposed, under the provisions of the bill.

Under the provision of the second bill, an employee would pay 4% of his earnings up to \$3600, or \$144 per year if his pay amounted to that figure. His employer would pay a like amount. Self-employed individuals would contribute 5% of their earnings. Assuming, therefore, that a small business man paid his employees a total of \$3600 yearly, and earned for him-

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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self, net, the same amount; his tax during the year would amount to \$144 to match the tax of his employees, plus 5% of his own income, or \$180, making a total of \$324.00. This is about the least that could be hoped for.

Actually, it is impossible to estimate what the cost of such a program would be. Undoubtedly it would rapidly expand when once started. That has been the experience in New Zealand which has been pointed to frequently as the model for such system. The New York Times recently estimated that under the proposed plan medical care in the United States would cost a total of around four billion dollars per year. Compare this with the 2.8 billions now expended. In addition to the above, there would be the vast sums required for construction and operation of numerous hospitals, medical centers, etc.

It has also been estimated that a minimum of 300,000 additional government employees would be required to operate the program. Actually, this may be a conservative figure.

ADMINISTRATION AND CONTROL — The Surgeon General of the Public Health Service is given full authority to administer the provisions of the bill, under the supervision and direction of the Federal Security Administrator, and after consultations with an Advisory Council and the Social Security Board. He is authorized to delegate any officer or employee of the Public Health Service or any federal, state, or local department or agency such of his powers and duties as he may consider necessary or proper. He is authorized to prescribe and publish rules and regulations and require records and reports as he may consider necessary in consultation with the Social Security Board and Advisory Council. He is directed to enter agreements with the Chief of the Children's Bureau of the Department of Labor to insure coordination in the administration of the services provided under the bill. Appointment is authorized of such personnel and in such grades as may be necessary in the Public Health Service for the proper and efficient administration of the act, to be assigned to duties in such divisions, sections or other units as the Surgeon General may find it necessary to establish, "without regard to limitations otherwise specified in the Public Health Service Act".

The bill provides for a National Advisory Medical Policy Council (the Advisory Council referred to above) to consist of the Surgeon General as Chairman and 16 members to be appointed by him, with the approval of the Federal Security Administrator, without regard to Civil Laws. The duties of the Advisory Council are strictly and purely advisory and consultative. Its advice and action is not made binding upon the Surgeon General or the Federal Security Administrator in any respect.

From present appearances administration of the entire program would be almost wholly in the hands of the United States Public Health Service, with the

Surgeon General the "Czar of Medicine," answerable only to the Federal Security Administrator, a Presidential appointee, without Cabinet status, and subject only indirectly and under the general provisions of the law, to Congress.

EDUCATIONAL PROGRAM CONDUCTED ON NATIONAL HEALTH BILL

The House of Delegates of the South Carolina Medical Association at its meeting in Columbia on January 3, 1946, took definite action authorizing a vigorous campaign to inform the public with regard to the implications of the pending National Health Bill, and appropriated the sum of \$1,000 for the purpose. The officers of the association were directed to take necessary steps in line with this action.

Subsequently, on March 3 Council issued a formal statement embodying its views and the position of the association on the bill and similar proposed legislation. The statement was given to the press and is printed in full elsewhere in this department. Definite plans were made sometime ago and now are being carried out, to further implement the action of the House of Delegates.

We wrote to doctors in twenty communities in South Carolina, requesting them to arrange with the persons in charge of programs in the various civic clubs and other organizations in their respective communities for the purpose of presenting a discussion of the Wagner-Murray-Dingell Bills, or the National Health Program. At the same time, a number of doctors who are fully qualified, were requested to make themselves available as speakers for the purpose of filling the engagements referred to. The response in both phases of the program was highly gratifying and judging by the reaction of the groups addressed so far, the results, we believe, will be well worth the effort. The doctors who have so willingly cooperated both in arranging the programs and presenting them, will be fully repaid for their efforts, not simply in the contribution which they are making toward the influencing of public opinion in the right direction, but also by the rekindling of their own individual interest in the problem and in the knowledge that they are performing an important service to the people of this country in helping to turn the tide which seems to be flowing so strongly away from the American democratic ideal, toward that of state ownership and control of everything.

To the present time, fifteen meetings have been arranged, and speakers supplied through this office. The programs are in Columbia, Charleston and in many of the smaller towns. The activity will be continued and by the time this appears it is hoped that there will be few communities in the state where the matter has not been presented.

Bearing in mind also that the doctors themselves in many instances need to be stimulated to activity, it



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has been proposed that like discussions be arranged for meetings of the district or county medical societies in each district in the state. Some of the Councilors have already followed the suggestion, with apparently splendid results. If their interest is sufficiently aroused, the doctors can do more than any other group in reaching the members of the public generally and acquainting them with the serious results which inevitably will follow if the bill is enacted into law, and which unfortunately so many people do not at this time realize.

BLUE CROSS ORGANIZATION PROGRESSES

After unavoidable delays of several weeks incident to the necessity of working out by-laws and contracts, the organization of the Blue Cross Plan in South Carolina is again moving rapidly forward. Shortly after the act was signed by Governor Williams in January, a meeting was held in Columbia of the group which originally sponsored the measure and piloted its course through the General Assembly. A free and healthy discussion of a number of questions involved was had at this time, whereby the way was opened for definite action at a future meeting. It appeared advisable, however, for several reasons, to increase the membership of the sponsoring group and after careful thought and study toward that end the additional members were selected.

As this is written the call for a meeting of the mem-

bership is expected momentarily, for the purpose of completing the organization, selecting the Board of Directors, adopting the by-laws and proposed contract and authorizing application for Charter. Barring any unforeseen development to further hamper the program, it is hoped that the organization will be set up and open for business within the course of the next six weeks.

DR. BROWNING AND DR. PRESSLEY TO ATTEND CONFERENCE IN CHICAGO

Dr. A. W. Browning of Elloree, and Dr. W. L. Pressley of Due West will represent the South Carolina Medical Association at a Conference on Rural Health which will be held in Chicago on March 30th. The conference will be held under the auspices of the American Medical Association and in conjunction with the American Farm Bureau Federation and other farm groups. Each state medical association has been urged to send two delegates.

"Since South Carolina is a rural state and in need of an expansion of her rural health activities, we are particularly interested in sending two strong representatives," commented Dr. J. P. Price, Secretary of the Association. "Dr. Browning and Dr. Pressley are general practitioners who know rural conditions in this state. Furthermore, they are highly respected by their patients and by their colleagues. We feel that they will give the representation which the state and which our medical association deserve."

PUBLIC HEALTH NEWS

DR. BALL RESIGNS AS MCH HEAD TO PRACTICE PEDIATRICS IN COLUMBIA

DR. SHERIFF APPOINTED MCH DIRECTOR

Dr. Robert Wilson Ball, Director of the Division of Maternal and Child Health, has resigned, effective March 15, to return to private practice. Dr. Hilla Sheriff, Associate Director, will succeed Dr. Ball as Director, a position which she held during his 5-year military leave of absence.

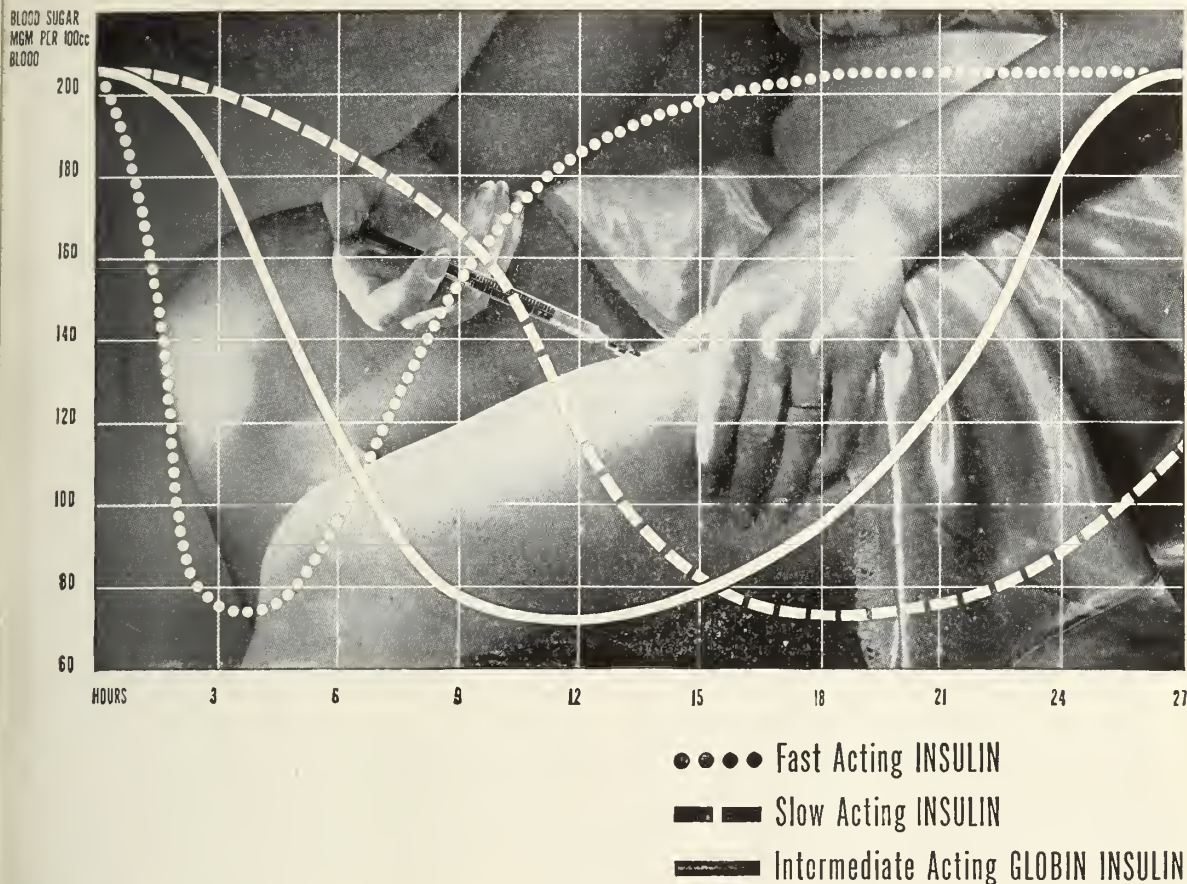
A former pediatrician, Dr. Ball has been with the State Board of Health since 1932 and has recently returned to civil life after serving with the armed forces since February, 1941. While overseas he was with the Tenth Army on Okinawa and toward the close of the war was attached to Headquarters, China Theater, Chungking, China. He held the rank of Lieut. Colonel in the Medical Corps when discharged.

Dr. Ball has announced that upon completion of a refresher course at Duke University he will practice pediatrics in Columbia.

FOOD HANDLERS TRAINING CLASSES

In 1944 the USPHS conducted two model food handler's training courses in South Carolina, one in Columbia and one in Charleston. Their purpose was to teach restaurant employees the modern scientific principles of preparing and serving food that is safe for public consumption. The keen interest shown in the courses by practically all restaurant managers in the two cities and their whole-hearted cooperation convinced health authorities that similar classes conducted in all towns and cities in the State would do much toward improving sanitary standards of South Carolina's eating places.

Mr. E. T. Ammons, Principal Sanitarian of the State Board of Health, was given the task of organizing and directing the program in all communities in the State which requested it. Mr. C. G. Leonard, Principal Sanitarian of the Spartanburg County Health



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THE PHYSICIAN now has a new intermediate-acting type of insulin with which to treat his diabetic patients—'Wellcome' Globin Insulin with Zinc. Originally there was only quick-acting, short-lived insulin. Then came a slow-acting, long-lived form. And now with Globin Insulin he has a moderately rapid-acting agent which persists for sixteen hours or more, enough to cover the period of maximum carbohydrate intake. This activity is sufficiently diminished by night to minimize nocturnal reactions. Physicians will do well to consider the advantages of this new third insulin for their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

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Department, was assigned by the State Health Officer to assist Mr. Ammons. Since November 1, 1945, when he returned to the State Board of Health from military service, Mr. T. P. Anderson, Junior Sanitary Engineer, and Mr. Ammons have been working together in carrying on the program.

Since the program started, 37 food handlers' training classes have been held in the following towns and cities: Columbia, Charleston, Florence, Camden, Bishopville, Georgetown, Orangeburg, Walterboro, Abbeville, Greenwood, Greenville, Pickens, Spartanburg, Gaffney, Union, York, Clover, Rock Hill, Fort Mill, Chester, Winnsboro, Greer, Barnwell, Hampton, and Manning. Charleston and Spartanburg County Health Departments have continued the program in their counties as a routine activity.

A description of the course arranged for and conducted in Florence, March 27, 28, 29, 1945, will show how the program has been carried on throughout the State.

Six weeks prior to the Florence School, which was requested by the City and County Health Departments, Mr. Ammons made a trip to Florence for the purpose of working out details. At the suggestion of the local health departments, the Chamber of Commerce was requested to participate as co-sponsor. After familiarizing themselves with the details, they entered into the program whole-heartedly. They furnished placards and merit certificates. Training placards were awarded to all establishments having 75 per cent or more of their employees attend all three classes. Merit certificates were issued to all employees completing the course. The Chamber of Commerce also handled the newspaper and radio publicity.

Included in the initial meeting was the County School Lunch Room Supervisor who gave her full support and interest. The YMCA Hall was donated for the course and all lights, cleaning, etc., were taken care of by that organization. A letter calling attention to the importance of having their establishments represented at a meeting to be held March 19 in the YMCA Hall at 3:00 P. M., to work out final plans and details for a food handlers' course, was prepared by the Chamber of Commerce and mailed to all eating and drinking establishments and school lunch rooms throughout the County.

The meeting on March 19 was presided over by the President of the Florence Chamber of Commerce. Mr. Ammons presented to the group the reasons for the food handlers' course and the benefits that could be expected to accrue as a result. An outline of the course was presented and a moving picture, "Eating out," was shown. The State Board of Health photographer was present and made some group pictures which were run in the local paper on Sunday prior to the opening of the course on Tuesday.

The opening session of the school was begun on March 27 promptly at 3:30 P. M., with the local County Sanitarian, Mr. J. H. McFarlane, presiding.

The meeting was called to order and the Director of the County Health Department, Dr. J. R. Claussen, was introduced. He, in turn, presented the guest speaker, Dr. W. R. Mead, a member of the Executive Committee of the State Board of Health. Dr. Mead emphasized the fact that South Carolina has ample food laws. He called attention to the dangers that could arise before the food is finally placed before the consumer. Special attention was directed to the virus and filth-borne diseases and the importance of proper training for all food handlers.

Next was a lecture on bacteriology explaining what bacteria are, where found, size, shape, etc. Also discussed was the method of propagation, the necessary essentials for rapid multiplication; namely, food, warmth and moisture, and proper methods for controlling them. The three common types of bacteria—harmful, helpful and useless—were discussed.

A demonstration picking up bacteria was made among the group by exposing prepared petri dishes to fingertips, coughs, hairs, flies, roaches, money and dust. These cultures were placed in a portable incubator for 48 hours at 370° centigrade. The results were exhibited at the last class of the school.

Following the demonstration was a lecture on communicable diseases, explaining the cause, mode, or channel of transmission and the proper methods for blocking the channel. Special emphasis was placed on the diseases most commonly spread from eating and drinking establishments.

The motion picture "Eating Out" was shown and narrated. At this first session, questionnaires containing true and false statements, along with other instructive reading material, were given to each student. Altogether it consisted of eight mimeographed pages which were to be used as home work and brought back to the last class for discussion and correction.

The State Board of Health Photographer was present at the first class and made pictures of the most important features.

In class two the lectures covered food poisoning and food preservation, with special emphasis on the most common types of food poisoning likely to be spread from public eating and drinking establishments. Also discussed were precautions to be taken to safeguard against these potentialities and the proper methods of storing and refrigerating foods.

Personal hygiene and good housekeeping were discussed, dwelling on the do's and don'ts of restaurant sanitation. Strees was laid on the point that everyone employed in a restaurant has his or her definite responsibility in the healthful maintenance of the establishment, and that the chain is as strong as its weakest link. The importance of insect and rodent control was discussed at length. The life history of the four most common offenders, flies, roaches, rats and mice, was given. The most modern methods of control were discussed in detail with demonstrations, and motion pictures pertinent to this subject were shown.

The First Year

THE SUCCESSFUL NUTRITIONAL history of S-M-A babies is due to the remarkable similarity of S-M-A to mother's milk. It is essentially the same as human milk in percentage of protein, fat, carbohydrate and ash, in chemical constants of the fat and in physical properties.

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S-M-A is derived from the milk of tuberculin-tested cows. Part of the butter fat of this milk is replaced with animal and vegetable fats, including biologically assayed cod liver oil. Milk sugar, vitamin A and D concentrate, carotene, thiamine hydrochloride, potassium chloride and iron are added.

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Class three consisted of exhibiting and explaining cultures picked up on the first day of the school. This was done by arranging them on tables and letting the students review them before entering into the lecture course.

A lecture on dish washing and sterilization, with demonstration including proper methods and importance of both, was given. The approved bactericides and how to use them and the importance of using approved dish washing compounds were discussed.

A review of the State Code and Ordinance Governing Restaurants and an explanation of the grade sheet was made very thoroughly in order that all employees might realize the part they play in the maintenance of their establishments. The true and false quiz was reviewed with the group, and all questions answered correctly. The Nutrition Consultant of the State Board of Health discussed the importance of properly balanced and prepared diets including the basic seven foods. Literature on various phases of nutrition was distributed.

The closing address was made by Mr. E. D. Sprott,

City Health Commissioner. He appealed to everyone to take the facts learned during the school and put them into practice to make eating out safe in Florence restaurants.

In order that more communities in the state might be given an opportunity to have their food handlers trained, it has been necessary to condense the three-day course into one two-hour period. Lectures, motion pictures, and certain other phases of the course have had to be considerably shortened, but, essentially, the course is still the same.

It is interesting to note that the school lunch workers are contributing much to the success of the program. Despite the fact that they work under adverse conditions in most cases, having to improvise in matters of buildings and equipment, their utensils invariably show low bacterial counts.

Mr. Ammons has announced that plans have been made for holding classes in the following places during the coming months: Darlington, Conway, Lancaster, Sumter, Moncks Corner, Kingstree, Marion, Bennettsville, Saluda, Anderson, Pickens and Aiken.

NEWS ITEMS

The post graduate committee of the Medical College Alumni Association announces that plans are being made for the annual Refresher Course and Founder's Day Program. Since all reputable physicians in South Carolina have been invited to become members of the Alumni Association, it is urged that all members of the Medical Association participate in the annual luncheon meeting at Myrtle Beach on May 1. At this time plans will be made for the year. The committee is particularly anxious to have suggestions for speakers and topics for discussion at the Refresher Course.

Dr. Richard B. Josey has returned to Columbia to resume the practice of pediatrics at his office at 1427 Pickens Street, Columbia.

Dr. Perry T. Bates of Greenville has returned from overseas service and is now on terminal leave.

Dr. Manly E. Hutchinson has returned to Columbia after five years of service in the army and expects to resume his practice immediately. He has recently been in Baltimore where he did refresher work in gynecology, to which his practice will be limited.

Dr. W. B. Timmerman has been discharged from the Army and has resumed his practice in Hartsville.

NEED FOR MEDICAL BOOKS IN MANILA

Some months ago the Academy-International of Medicine and Dentistry moved its executive office from St. Paul, Minnesota, to the Liberty building, Topeka because of its central location. According to the executive secretary, Mr. J. B. Young, one of the projects of this organization is to attempt to supply the destroyed medical library at the University of Manila with sufficient books to enable the school to operate.

It is well known that the Japanese destroyed the university and its library until almost no piece of usable equipment remained.

The Academy-International of medicine is appealing to the medical profession all over Canada and the United States to donate books that may be sent to Manila. Already 10,903 individual publications are in transit and many more are needed. These books have come from individuals, from medical libraries, medical schools and clinics.

Kansas doctors are invited to assist in this worthwhile undertaking through the contribution of books, periodicals or cash. Doctors willing to donate books should first write to Academy-International of Medicine, Liberty building, Topeka, giving the names and authors and edition numbers of the books that are available. In an effort to send only material that is critically needed and to avoid duplication, all gifts should be cleared before they are sent. The donor will then be instructed which of these books are desired.

If cash is given, the donor may be assured that all money will be used for the purchase of needed texts, that arrangements have been made with leading publishers to sell books for this purpose at cost, and that they will be forwarded immediately to the School of Medicine, Univ. of the Philippines. Make all checks payable to: Manila Library Fund, A-I.M.

"A one week didactic and clinical refresher course in Otolaryngology has been arranged for Specialists in the field, from May 13th to 18th, 1946, inclusive. Applications for registration should include school of graduation, training and experience. Check for tuition (\$50.00) should accompany the application.

In addition, a special course in Broncho-Esophagology will be given from June 3rd to 15th, 1946, in-

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26TH SESSION

MEETS JULY 15 - JULY 27, 1946,

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George Dean Johnson, M.D.,
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clusive. It will consist of lectures, animal and cadaver demonstrations, diagnostic and surgical clinics.

The course will be under the direction of Drs. Paul H. Holinger and Albert H. Andrews, Jr.

Tuition for this Course is \$100.00. Check should accompany application. Class limited to twelve physicians.

For further information address:
Department of Otolaryngology
University of Illinois College of Medicine
1853 West Polk Street
Chicago, Illinois

The next oral and written examinations for Fellowship in the American College of Chest Physicians will be held at San Francisco on June 29, 1946. Applicants for Fellowship in the College who plan on taking the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Illinois.

The Twelfth Annual Meeting of the College is scheduled to be held at the Sir Francis Drake Hotel, San Francisco, June 29-30, July 1-2.

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS, MEETS IN DETROIT

The International College of Surgeons, United States Chapter, will hold its Eleventh Annual Assembly and Convocation in Detroit, Monday, Tuesday, Wednesday, October 21-22-23, 1946.

Surgical clinics in Detroit hospitals will feature the first morning of the Assembly. Thereafter all the meetings, the Convocation, and the Exhibition will be held in the Masonic Temple, a splendid building affording every convenience. The Detroit Statler and the Book-Cadillac will be hotel headquarters.

Officers of the International College of Surgeons, United States Chapter, include President Herbert Acuff, M. D. of Knoxville, Tennessee; President-Elect Custis Lee Hall, M. D. of Washington, D. C.; and Louis J. Garipey, M. D. of Detroit, Executive Secretary. Dr. Garipey, General Chairman of Arrangements for the Detroit Assembly advises that satisfactory housing accommodations for the 1946 Assembly have been assured through the Detroit Convention & Tourist Bureau. Copy of Program and detailed information may be obtained by writing Dr. Garipey at 16401 Grand River Avenue, Detroit.

PLANS ANNOUNCED FOR 1946 CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS IN NEW YORK

The American College of Surgeons announces that

arrangements have been completed for the holding of its Thirty-second Clinical Congress at the Waldorf-Astoria, New York, September 9 to 13 inclusive. Plans include the usual extensive program of demonstrations, scientific sessions, panel discussions, symposia, forums, Hospital Standardization Conference, medical motion pictures, business meetings, and educational and technical exhibits, which will be held in the headquarters hotel, and operative and non-operative clinics in the local hospitals.

This will be the first Clinical Congress since the meeting in Boston in 1941. Since that time, 2,744 surgeons have been received into fellowship in absentia, and to them in particular the Convocation on the opening night of the Congress will be a long anticipated event. Many of these new Fellows will have recently returned from service with the armed forces. The formal initiation ceremonies, always impressive, will be exceptionally so this year because of the large number of new Fellows admitted during the past four years who are expected to be present.

Officers, Regents, and Governors have remained in office since 1941 because of the cancellation of annual meetings of the Fellows. Especial interest will also therefore be attached to the installation of the officers-elect, headed by Dr. Irvin Abell, Chairman of the Board of Regents, as President. Dr. W. Edward Gallie of Toronto has been President since November, 1941. Dr. Gallie will give the Presidential Address at the Presidential Meeting and Convocation on the evening of September 9 in the Grand Ballroom of the Waldorf-Astoria.

Dr. Howard A. Patterson and Dr. Frank Glenn of New York City are Chairman and Secretary respectively of the Committee on Local Arrangements. Dr. Henry Cave of New York, a member of the Board of Regents of the College, is also active in directing the local plans for the meeting, attendance at which is usually around five thousand surgeons and hospital representatives.

CHESTER COUNTY MEDICAL SOCIETY MEETS AT GREAT FALLS

The Chester County Medical Society met at the Dearborn Inn at Great Falls on Wednesday, March 6th at 8:00 P. M. as the guest of Dr. & Mrs. J. B. Floyd and Dr. W. T. MacLaughlin. A delicious three course chicken dinner was served. The tables were attractively decorated with flowers and long white tapering candles. Dr. A. M. Wylie, president, presided. Mrs. J. B. Floyd and Miss Janie Lee Medlin (Dr. Floyd's office Nurse) were present, but left when the medical program began. Chester doctors present included: Dr. W. R. Wallace, Dr. A. M. Wylie, Dr. W. J. Henry, Dr. G. A. Hennies, Dr. R. D. Hicks, and Dr. V. P. Patterson. Among the out-of-county guests were

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AIKEN, SOUTH CAROLINA

Dr. Tom Brockman (President of the South Carolina Medical Association), Dr. Euta Colvin and Dr. Judy of Greenville; Dr. George Bunch, Dr. Tom Pitts and Dr. Ben Miller of Columbia; Dr. Chalmers Hope, Dr. Elias Faison and Dr. Dessie Gilland of Charlotte; Dr. Crawford, Dr. Barber, Dr. Belk, Dr. Pittman, and Dr. Lippert of Lancaster; and Dr. Shippey and Dr. McDonald of Rock Hill.

Dr. Floyd had charge of the program. He presented Dr. George Bunch, who gave a lantern slide talk on "Cancer of the Breast." His fine paper was discussed by Drs. Pitts, Wallace, Henry, Shippey, and Brockman.

The second speaker was Dr. Ben Miller, who read a splendid paper on "Causes of Chest Pains", illustrated by case histories and lantern slides.

Dr. Wylie read a letter from Dr. Austin T. Moore of Columbia inviting the officers of each county Medical Society to attend the Columbia Medical Society meeting on March 11th to hear Dr. Harrison H. Shoulders (President-elect of the American Medical Association) speak.

Dr. Tom Brockman explained briefly why the State Medical Association meeting to be held on April 31, May 1st and 2nd was changed from Greenville to Myrtle Beach.

The doctors gave a rising vote of thanks to Dr. Floyd and Dr. MacLauchlin for their tasty dinner, fine program, and warm hospitality.

ABBEVILLE COUNTY MEDICAL SOCIETY

The Abbeville County Medical Society held its February meeting at the Memorial Hospital with a full attendance. Dr. Georgiana Edwards, President, presided and extended a warm welcome to the young doctors who have recently been discharged from the service.

Election of officers of the Society for 1946 was held with the following results: President, Dr. Ellis Poliakoff, Vice President, Dr. Ward of Calhoun Falls, and Secretary-Treasurer, Dr. Francis McLane.

CORRESPONDENCE

To the Editor.

I was particularly pleased to see that *Ye Olde Journal* finally made the big time in literary circles. I refer to the recent story in *Time* magazine under Medicine concerning President Roosevelt's "case history". Although such a story could hardly go unnoticed, it was gratifying to see the credit which was given to our own state publication, and it is but another example of the discrimination which you and your staff have consistently shown in formulating our *Journal*. More power to the able editorial staff of our fine medical magazine.

J. H. Stokes

NEWS ITEM

Dr. J. Gordon Seastrunk has been awarded his fellowship in the American College of Chest Physicians.

DEATH

Dr. John L. Fennell of Waterloo, died February 27, at the age of 68. A graduate of the University of Georgia School of Medicine in the class of 1902, Dr. Fennell had practiced his profession since that time. For many years Dr. Fennell had served his county medical society (Laurens) as Secretary-Treasurer. He was an Honorary Member of the S. C. Medical Association.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. Vance W. Brabham, Orangeburg, S. C. Publicity Secretary: Mrs. P. J. Boatwright, Orangeburg, S. C.

The Woman's Auxiliary to the South Carolina Medical Association will hold its convention at Myrtle Beach on April 30, May 1. The Ocean Forest Hotel will be headquarters. Tentative plans call for a Dutch supper for the Executive Board at 6:30 P. M. on Tuesday, April 30, followed by a meeting of the Student Loan Fund at 8:00 P. M., and a meeting of the Executive Board at 8:30 P. M. The House of Delegates will meet at 9:30 A. M., May 1, followed by a program meeting at 11:30. Mrs. David W. Thomas, President of the Woman's Auxiliary to the American Medical Association, of Lock Haven, Pennsylvania, will be the guest speaker for the program meeting.

The Woman's Auxiliary to the Columbia Medical Society met with Mrs. William Weston, Jr., on Tuesday, January 8. Mrs. Clyde Helms, Chief of the Child Welfare Division of the S. C. Department of Public Welfare, was the speaker. Mrs. Helms gave an interesting view of the problems of the children of South Carolina and told of the facilities available to meet these problems. Plans for the annual azalea sale were discussed and it was announced that the

sale will probably be the latter part of March.

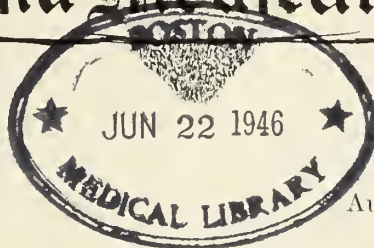
The luncheon meeting of the Woman's Auxiliary to the Spartanburg County Medical Association was held on Wednesday, February 27, at the Cleveland Hotel with Mrs. Vance W. Brabham of Orangeburg, President of the State Association, as guest speaker. Mrs. Brabham was introduced by Mrs. W. H. Folk. "Animal Experimentation" was the topic of the address. "The advances in the healing art have come about largely through the use of animals," said the speaker. In closing her remarks Mrs. Brabham said, "My only explanation of the attitude of those who are opposed to scientific animal experimentation is this, 'they are down on it because they are not up on it.'" Following the luncheon and prior to Mrs. Brabham's address, Mrs. W. G. Hantske gave several humorous readings from her book "The Song of the Cotton Pickers." Mrs. W. T. Hendrix, President, presided and welcomed several guests including Mrs. S. Harry Ross of Anderson, President-Elect of the Woman's Auxiliary to the South Carolina Medical Association.

52

The Journal of the South Carolina Medical Association

MAY, 1946

VOL. XLII, NO. 5



Article

Author

Page

Chronic Disease of the Breast	Kenneth M. Lynch, M. D.	111
Helpful Considerations in Diagnosis of Surgical Cases of Jaundice	Marion L. Mathias, A.B., M.D.	115
Disabilities of the Foot	F. A. Hoshall, M.D.	117

President's Address — Editorials — The Ten Point Program — News Items — Public Health News — South Caroliniana — Correspondence — Book Reviews — Deaths

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¹ Virginia M. Monthly
72:240 (June) 1945.



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Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

May, 1946

NUMBER 5

Chronic Disease of the Breast

KENNETH M. LYNCH, M. D., CHARLESTON, S. C.

The broad and non-specific nature of the title of this presentation reflects an admission—of lack of sufficient knowledge even to construct a complete or final name for a very common state of disease.

Probably the most generally used name for the class of disease in mind here is chronic mastitis or chronic cystic mastitis, and yet none in use is likely to prove to be less appropriate, for of one thing we are convinced that it is not inflammatory in primary nature. This name chronic mastitis was first applied by Koenig, in 1893.

Many attempts have been made to construct a suitable title and such as Schimmelbusch's "cystadenoma mammae," or merely Schimmelbusch's disease, adenomatous proliferation, senile parenchymatous hypertrophy, abnormal involution, polycystic degeneration, fibro-adenomatosis, cystiferous epithelia hyperplasia, cyclomastopathy, adenocystic disease, proliferative mastitis, adenosis, mazoplasia and mastoplasia, come to mind. Even adenoma or fibroadenoma and duct papilloma must be counted in the class, although these terms usually have a limited application.

It will be noted that all of the names that do not frankly beg the question are given because of some special feature, although none covers all the features encountered. The Department of Pathology at the Medical College of South Carolina has for some time been using the term mastoplasia, as signifying a hyperplastic disease, under some abnormal growth stimulus, which is apparently hormonal and periodic.

The importance of the disease in question lies not so much in the fact of its common occurrence, for it is not in itself disabling or more than occasionally even inconveniencing, but especially because of possible confusion with cancer or even actual relation to the production of cancer. Common inability of a medical examiner to determine whether a lump in the breast is cancer or merely a benign nodule of hyperplastic and perhaps cystic gland, itself warrants surgical excision, but if such a nodule may become malignant,

The Author:

Dr. Lynch is Dean of the Medical College of the State of South Carolina and Professor of Pathology.

then double is the reason to excise it.

At the beginning of the development of a distinct department of pathology here, now 32 years ago, the state of knowledge of so-called chronic mastitis was indeed limited. Perhaps others may then have had better ideas but generally the conception was that it represented chronic inflammation.

Because that was the heyday of the theory of chronic irritation as the cause of cancer and because cancer of the breast was common, there seemed little reason to doubt that a woman who possessed a lump of the breast was in grave danger of cancer, and breasts were removed almost as freely as were ovaries.

Now it is logical that a woman without breasts cannot have cancer of the breast and while some may prefer to lose these organs to taking a chance, yet women generally are somewhat strong headed in the matter, and the solution of the cancer of the breast problem is not that simple.

Even so, many a young woman who might have been spared that handicap until a day when it should make less difference, lost their breasts, one or both, because of cancerphobia in her doctor as well as in herself. Two schools of far apart thought prevailed. One said "As long as a lump in the breast doesn't bother you don't bother it," and the other wielded the knife on suspicion. Both schools were and are schooled badly.

In free and easy diagnosis and amputation, many recorded but not true cancers of the breast have been cured, and cancer cure statistics, even from high levels of professional reputation, are in reality largely untrustworthy.

To add confusion to the picture, there came during this era the widely spread practice of rapid section diagnosis during the operation, the so-called frozen section.

Pathologists seldom have had the opportunity of standing in the floodlights along with the surgeon, and they took to the frozen section as a chance to occupy the glorified position.

Now I am not one to take away the use of frozen section technic for preparing microscopic slides when it may serve as a worthy purpose but as a measure used to furnish a diagnosis by the clock during an operation, I am sure that frozen section has done more harm than good.

While frozen section examination during operation has been heavily depended upon for quick diagnosis and as a guide to extent of an operation in many types of cases, especially of tumors or suspected tumors, and even in examination of uterine scrapings, the procedure has probably been used more in disease of the breast than in any other. In this practice there is some danger and little profit.

In the judging of a lump excised from the breast for diagnosis, I would rather depend upon gross examination by the surgeon or the pathologist, in one person or two, or more, as the case may be, than upon a frozen section examination by a pathologist or surgeon who was himself incapable of making a reasonable decision from the gross.

A few times—fortunately very few—in my professional youth, I have been guilty of giving an opinion of malignancy in a frozen section examination of the breast at operation when that judgment could not be made from examination of the gross specimen. I now believe that I erred—from inexperience and lack of matured wisdom in such matters—and there are several women now of middle age, then young, who suffered severe operations and resulting handicaps, but who at least believe that they were cured of cancer.

Although no one should be excused for failure to stand on his own convictions when they are soundly based, many times has a pathologist been so closely "on the spot" by the demand that he be able to do what popular professional propaganda said that he should do, that he was unable to stand against it. Far too commonly he was himself a party to the propaganda.

At least as long as twenty-three years ago I had come to feel so strongly that frozen section diagnosis was so overrated and so much subject to abuse that I published my own opposition to it.

In the first place a cancer large enough to come to observation has visible and textural features which are practically unmistakable to one of such experience as should be had to justify his acceptance of such responsibility. Conceivably either a practicing surgeon or a pathologist or both together might be unable to identify these features, but in such event neither would they be likely to produce a better judgment from a frozen section microscopic examination.

Further, a nodule or mass of breast tissue the seat of mastoplasia, whether cystic or not, itself has an appearance and texture not commonly confusable with cancer.

Nowadays a competent pathologist acting as consultant at an operation upon the breast will usually make up his mind when he sees and cuts and feels the lump, and as far as I am personally concerned, what the microscope shows him on quick section merely confirms his opinion or it fails to do so at that moment.

When there is reasonable doubt as to the true condition, there is no material disadvantage in awaiting a deliberate and thorough study. When there remains question after such a study, it is a practical adage, adhered to for many years to my satisfaction, that when a breast lump is not clearly malignant, when there is doubt from the microscopic picture, then it is benign.

At times it requires the strength of experience to hold to that as a working rule, but adherence will rarely give cause for regret, while the practice of playing safe in treating doubtful cases as malignant will commonly result in abuse of those to whom we owe responsibility.

But, it may be contended that there must be borderline conditions to commonly come to attention, and that is unfortunately true, whether we accept that mastoplasia may at times be a precursor of cancer or not. Both conditions are common enough that they would naturally occur coincidentally.

It is in this border region that the greatest degree of experienced judgment is required for fully competent service, and not much more than just that may be said about the criteria for a differentiating decision. They reside more in the accumulated experience of the examiner than in features which may be described for identification by others. One does not look through a microscope to see an equation which automatically produces a result.

Experience necessary for a clear diagnosis of uncomplicated mastoplasia, or of adenoma, or of developed cancer of the breast is not great, but there is no occasion in medical practice which demands a greater experience and maturity of judgment than in the zone where mastoplasia and cancer meet.

Adenoma, duct papilloma, which may include cystic adenoma, mastoplasia, and even cancer of the breast, perhaps may be considered based upon sex hormone stimulation in a susceptible gland, which is probably to say, a susceptible woman. The bearing of children has nothing to do with any of these conditions however.

Adenoma, or fibro-adenoma, is the least bothersome of the class. It usually begins in the breast of early maturity, commonly at or soon after puberty, although

if not removed it will remain, and may reach substantial size. After the menopause an old adenoma may become dense and hyaline or even calcified.

A spherical, firm, freely movable nodule in the breast of a young woman has little chance to be anything but a simple adenoma. It probably never becomes a cancer, although a possible serious transformation may produce sarcoma of the stroma element.

Since it should be removed, the sooner the better. Then we may be positive of its nature. It requires no great experience to identify without doubt the common encapsulated fibroadenoma with its characteristic granular lobulation and its histological structure, although that may be somewhat varied.

Occasionally this typical fibro-adenoma structure may be an unencapsulated part of benign mastoplasia, particularly in the later years of life.

One of the intriguing varieties is lactating adenoma, an encapsulated nodule of lactating gland within a non-lactating breast.

Duct papillomas, including all benign glandular growths within the ducts, are more exciting to the examiner of limited experience. These growths are obviously usually parts of definite mastoplasia and probably are but a phase of that disease.

Since they grow within the ducts and are delicate structures, they may bleed or exude, and a secretion, commonly colored, from the nipple is often associated with the lump in the gland. Obstructed ducts dilate and often the related gland is cystic.

Commonly this form of growth appears to be single but there is probably always some degree of mastoplasia associated. Frequently there are numerous papillomas in the aggravated phase of proliferative disease. I have seen breasts occupied by great numbers without malignant consequences.

Papillomas are seldom diagnosable as such in the unexplored breast. They may be suspected from nipple bleeding. They are usually embedded in a mass of cystic hyperplastic disease, and from examination of the breast may be impossible to differentiate from cancer. Such breast lumps should always be removed for proof of their nature.

Because of the common association of duct papillomas and periductal glandular growth, the appearance of malignant infiltration may be given. This offers one of those difficult problems of histological judging to which reference has already been made.

Many duct papillomas have been judged malignant when they were not. Mastoplasia is uncommon before the early thirties, it is exceedingly common in some degree from the middle thirties to the sixties. When seen well after the menopause it may have begun at or before that event.

It is cyclical in its phases, even as the growth

and involution of the gland is normally in monthly periods. Attention to this fact will be of value to the physician and his patient. One or more lumps in the breast, to arouse alarm in the lutein phase of a woman's cycle, may disappear with menstruation. Cysts may quickly appear during this growth period. A rounded nodule suddenly appearing of material size is almost certain to prove a cyst.

Mastoplasia may exhibit itself in the intact breast as a lump, as separate humps, or as general lumpiness, possibly apparent only in one gland but usually demonstrable in the other, even if not in comparable degree. At times the duct system may feel diffusely corded and knotted.

General lumpiness without a demonstrable or definite nodule is the least alarming of the variable features. A single irregular firm nodule cannot be differentiated *in situ* from cancer.

Mastoplasia may also occur in the breast of the male. Here unfortunately attention becomes focused on the breast, and tragedy may result from failure to remember that the cause of the condition is abnormal hormonal stimulation, and that a tumor of the testicle may be the background. The important thing is locating the cause, particularly to bring the testicle under suspicion, not especially to remove the breast.

That cancer of the breast may occur on the basis of mastoplasia has long been a belief of some but only recently has acceptable proof been offered and only statistical proof at that. In an intervening period causative connection was largely discredited. From the extensive and careful statistical surveys of Shields Warren and an associated Massachusetts group it now appears that a woman with proven mastoplasia is at least more likely to have cancer of the breast than is the average woman of the whole population.

Certainly, however, it cannot be said that a woman with even aggravated mastoplasia shall by that fact inevitably come to have cancer.

Even though it may be accepted that a woman with demonstrable mastoplasia is on the average more liable to cancer than is the average woman with normal breasts, that is not to say that any individual is in danger of cancer. There is something more than mastoplasia to the qualifications for bearing cancer of the breast.

It is this unknown factor that puts us on guard. The susceptible woman cannot be distinguished from the non-susceptible.

Generally speaking the rules which may be made from present knowledge of these diseases of the breast, for guidance in our course of procedure in guarding the interests of patients to the best of our opportunities are rather simple. They relate to age periods, relation to menstruation, physical examination of the breast, and examination after excision.

Some few oncologists have developed some additional aid by methods of visualization, such as transillumination and roentgenography. At times aspiration of what is believed to be a cyst is justified. I am unable to credit minute biopsies in such a serious business as this. In physical examination of a lump in the breast, let handling be definite but careful. Cancer cells are more easily disseminated by squeezing than by incising.

The general rule should be, that any definite nodule in the breast which does not disappear or at least recede to indefinite proportions with menstruation should be explored, and that means, practically, complete excision and thorough examination, including careful histological study.

A second general working rule should be: in the examination of the excised specimen, if the gross examination at the operation does not completely satisfy those there responsible, regardless of whether a frozen section is done, the specimen should be submitted to deliberate and careful pathological study before a final decision is reached. No woman should be subjected to extensive radical surgical measures or to irradiation unless cancer is proven. On the other hand, when there is a possibility of cancer, every woman is entitled to the best service, pathologic and therapeutic.

In the application of these general principles, proper courses of procedure in the several types of circumstances appear to be reasonably well outlined.

One or more rounded nodules in the mammary gland of a woman between puberty and age thirty may be subjected to local excision at an early convenient time. Since such a nodule will usually prove to be adenoma, that will ordinarily suffice. Of course, preparation should have been made for an alternative course, should it prove to be definite cancer.

A lumpy breast at any age should be carefully

observed. If there is no definite nodule, there is no urgency for consideration of amputation, and biopsy would be without definite point.

Whether or not such a breast should be removed as a precautionary measure should depend upon the patient's attitude. Continued close observation may be even encouraged in a woman of the child bearing period or in anyone with the commendable desire to retain this altogether feminine appendage.

A definite nodule within a lumpy or corded breast calls for close attention. In the post-menopausal period there is no good reason to delay its exploration. Prior to that age, especially in the thirties, unless it is truly alarming, a degree of procrastination is warranted. If it recedes with menstruation, it is certainly not cancer then. If it recurs, there is no justification for long continued delay.

Periodic lumpiness or even indefinite nodularity occurring with the menstrual cycle is a condition not as thoroughly in our minds as it should be.

Because cancer often occurs without apparent relation to or association with mastoplasia, women should be schooled in the habit of frequent examination of their own breasts. A single firm nodule in an otherwise normal breast is subject to more suspicion than is an indefinite one in a lumpy breast. Usually it should be immediately explored, especially in the age period beyond the late thirties.

Of course, when circumstances and careful examination make the diagnosis probable or apparent cancer, any operation should be designed from that standpoint and not merely for excision and diagnosis.

That too many cancers still come to us in advanced state reflects our own failure to fully provide our best services to the people, and, also, too common failure to follow certain simple rules of procedure, based upon accumulated experience, in caring for those who do come to us in time to be helped.

Helpful Considerations in Diagnosis of Surgical Cases of Jaundice

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Jaundice is a condition in which the tissues become stained with bile pigment; it is a symptom of a disease whose treatment might be surgical or medical. The purpose of this paper is to set forth considerations that help to determine whether a case of jaundice can be benefited by surgery or not.

ANATOMICAL CONSIDERATIONS: The liver is divided into lobules, the cells of which are arranged in test tube-like columns around a branch of the hepatic vein. The closed end of the test tube is placed centrally. The lobule is surrounded by branches of the portal vein. The blood flows in sinusoids around the outside of the test tube-like columns into the hepatic vein at the center of the lobule. The open end of the test tube forms a duct which joins that from other columns and eventually forms the hepatic duct.

The hepatic duct emerges from the substance of the liver and is joined by the cystic duct forming the common bile duct. The common bile duct is about 9 cm. long and passes downwards, behind the duodenum, in a groove of, or behind, the head of the pancreas and enters obliquely into the descending duodenum with the pancreatic duct through the ampulla of Vater.

PHYSIOLOGIC CONSIDERATIONS: Bile is formed by the parenchymatous cells of the liver and collects in the interior of these test tube-like columns of cells. It flows from the liver through the bile ducts into the duodenum. When bile is not needed in the intestines for the digestion of food, the sphincter of Oddi about the orifice of the ampulla of Vater closes and bile backs up into the gall bladder where it is concentrated and stored until needed.

In a discussion of jaundice the chief pigment to be considered is bilirubin. Bilirubin is formed from red blood cells which are broken down by the cells of the reticulo-endothelial system into an iron-containing fraction and a non iron-containing fraction called bilirubin. It circulates in the blood and is removed by passing through the liver cells. If there is an excessive break down of hemoglobin (as in hemolytic jaundice) or if the biliary passages are diseased so that bilirubin can not be excreted, bilirubin will accumulate in the blood. The blood serum then takes on an orange yellow color, and the tissues become stained with the pigment.

The parenchymatous cells of the liver extract bilirubin from the blood stream, remove a protein molecule from it, and pass it into the bile capillaries. In

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losing this molecule of protein by its passage through the liver cells the structure of the bilirubin has been changed somewhat, but it is still referred to as bilirubin or cholebilirubin. In the bile it passes into the intestines where it is changed by the action of bacteria into urobilinogen. A large part of the urobilinogen passes out in the stools, to which it gives the characteristic brown color. Another part of the urobilinogen is reabsorbed into the blood stream and carried back to the liver by the portal vein; this part is again excreted into the bile capillaries. A small part of urobilinogen while in the blood reaches the kidney and is excreted in the urine. *Therefore, freshly voided urine normally contains a small amount of urobilinogen but no bilirubin.*

The most valuable laboratory examinations for differentiating surgical from non-surgical jaundice are:

1. **X-RAY:** A flat plate x-ray is useful. This might show a stone in the hepatic duct or in the common duct. Stones in the gall bladder do not cause jaundice. All stones do not cast x-ray shadows; varying with the geographic locality approximately 60% can not be visualized with the x-ray. In the presence of jaundice an x-ray with the use of dye (the Graham-Cole technique) is of no more value than a plain plate because the dye goes where the bile goes, that is, into the tissues.

2. **THE ITERIC INDEX DETERMINATION:** The iteric index is a measure of the amount of bilirubin in the blood. Bilirubin accumulates in the blood because of excessive hemoglobin destruction or because of disease in the biliary or hepatic tract which renders impossible the excretion of the normally formed bilirubin. Due to the fact that carotene and other pigments occasionally cause confusion a quantitative van den Bergh determination may sometimes be preferred to the usual iteric index. Normal blood serum contains as much as 1.7 mg. of bilirubin per 100 cc. In practice the qualitative van den Bergh reaction is of little value because the presence or absence of bile in the urine gives the same information. The kidney filter allows bilirubin that has passed through the liver cells to be excreted, whereas bilirubin that has not passed through the liver

cells is retained in the blood. In jaundice produced by liver disease the urine contains bile; the urine contains no bile when jaundice is produced by excessive hemolysis. In obstructive jaundice the amount of bile in the urine varies with the completeness of the obstruction.

3. **THE EXAMINATION OF THE STOOL FOR THE PRESENCE OF BILE:** The presence of bile in the stool is indicated by the color. As the amount decreases, the color becomes tan, then yellow, and finally clay colored when no bile is present. Since constipation and other factors cause varying amounts of bilirubin to be excreted daily, repeated examinations will be necessary. A stone in the common duct seldom produces persistent and complete biliary obstruction, and repeated examinations will show fluctuations in the color of the stool. Hepatocellular liver disease frequently produces a marked decrease in the amount of bile excreted into the intestines, and the stools may show a very light color for several days; it seldom gives persistently alcoholic stools. Urinary urobilinogen also varies with fluctuating excretion of bile into the intestines. In hepatocellular disease the excretion is much greater than in the case of common duct stones because of the decreased ability of the liver cells to excrete urobilinogen. Obstruction in neoplastic disease once it has formed completely is persistent, and the stools remain clay colored.

4. **UROBILINOGEN EXCRETION:** Urobilinogen is formed by the action of bacterial enzymes acting upon the bilirubin which reaches the intestine. Some of the urobilinogen is absorbed through the intestinal wall into the blood stream. Most of it is removed by the liver and again excreted in the bile, but a small quantity normally reaches the kidneys and is excreted by them. Normally, therefore, freshly voided urine contains a small amount of urobilinogen. In cases of jaundice useful information is obtained by the examinations of 24 hour specimens. Normally 0.5 to 2 mg. of urobilinogen appears in the urine in 24 hours. If bile does not reach the intestines, no urobilinogen is formed. Therefore, very low levels of urobilinogen in the urine almost always indicate biliary obstruction and fluctuating levels suggest intermittent obstruction. Very high levels in the urine almost always indicate severe liver disease. This latter fact is true because the ability of liver cells to excrete urobilinogen is limited, and slight damage causes an increased amount of urobilinogen to be retained in the blood stream. The matter becomes even more complicated since biliary obstruction almost always produces some degree of liver damage and a consequent increase in urinary urobilinogen. However, urobilinogen excretion in jaundice due to obstruction seldom reaches the high levels observed in hepatitis.

5. **LIVER FUNCTION TEST:** The hippuric acid excretion test is one of the most helpful in

appraising the functional capacity of the liver. It has little value in differential diagnosis because it shows some degree of impaired function in nearly every type of liver disease. The test measures the ability of the liver to change benzoic acid into hippuric acid which is excreted in the urine.

The liver is largely responsible for the maintenance of protein balance of the plasma. When the liver cells are damaged, albumen decreases and globulins increase. Some of this increase is probably due to the presence of abnormal globulins. Several tests have been devised to show this change in the plasma proteins. The most useful is probably the cephalin-cholesterol flocculation test.

UROBILINOGEN EXCRETION IN JAUNDICE*

	Urobilinogen Milligrams	
	Per Day	
	Urine	Feces
1. Obstructive Jaundice		
Uncomplicated stone -----	0-6	10-250
Stone with cholangitis or biliary cirrhosis -----	4-50	10-250
Neoplasm -----	0-0.3	0-5
2. Hepatocellular Jaundice		
Cirrhosis -----	4-100	8-200
Hepatic disease with increased blood destruction -----	20-200	300-1200
Acute hepatitis -----	4-200	10-300
3. Hemolytic Jaundice		
Uncomplicated -----	1-10	300-1800
Complicated by infection, anemia, hemolytic crises, infarction or anesthesia -----	10-300	300-2500

*After Watson, Arch. Int. Med., 59:522, 1937.

SUMMARY:

1. Repeated and simultaneous examinations of the stool for the presence of bile and of the urobilinogen excretion will be valuable in the determination of jaundice that can be helped by surgery.

2. In general low levels of urobilinogen in both the urine and the stool indicate biliary obstruction. High urinary urobilinogen with normal or low fecal urobilinogen suggests intrahepatic disease. High levels in both the urine and the feces probably indicate excessive hemolysis of blood combined with liver damage.

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Disabilities of the Foot

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Before disabilities of the foot can be considered some remarks about important evolutionary changes must be presented. The fact that the human foot adapted for walking on the ground bears a closer resemblance to the ape foot as used in arboreal than in terrestrial locomotion may be regarded as an indication of man's arboreal ancestry. The most important evolutionary change in comparison with the chimpanzee is a transverse tarsal joint which is freely moveable in the latter while in the human foot, with the well developed longitudinal arch, it is relatively immobile. In the human the transverse tarsal joint is fixed in plantar flexion. This is probably due to shortening of some connective tissue as the plantar aponeurosis, the long plantar ligament and the inferior calcaneo-scaphoid ligament. It could also be accounted for by changes in muscle action. Another evolutionary feature, a transverse lateral process of the calcaneus of man prevents extensive movements of eversion of the astragalus, while in the chimpanzee this process is not as well developed and is more posteriorly. The chimpanzee has a well developed transverse arch while it is poorly developed in man, an indication of less functional weight bearing in this region of the human foot. In the human when the heel is lifted, the weight is distributed over the ball of the foot. This is not possible in the chimpanzee for when the heel is lifted, weight is transferred to the toes. Other evolutionary changes are shortening of the four lateral metatarsals; increase in the relative length of the cuboid, navicular and first and second cuneiforms; increase in stoutness and length of the calcaneus.

Although the gorilla resembles man more closely than does the chimpanzee in the relative shortness of the lateral digits, it shows no indication of the more fundamental changes as listed above which are essential for the development of the human foot.

The most significant feature in man's evolutionary history has been the adoption of the upright position. While there can be little doubt that as a direct and immediate consequence of the emancipation of the forelimb thus attained there arose an ability to explore with an unaccustomed precision, and later to utilize whatever came within range. The examination of the surrounding world must have been a profound educative influence upon a brain already ripe for expansion.

Our ancestors of many years ago used their feet for grasping. As these animals increased in bulk, whatever the cause, the habit of brachiation became an impossible mode of progression and so with retention of the upright attitude the feet were now forced to carry a large proportion of the body weight.

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The early shuffling gait of pre-man, like that of the present day anthropoids, was certainly assisted by the use of the hands but as time went on orthograde progression became more perfect, the hand was completely liberated and the feet had to sustain all the stresses and strains connected with the carriage of the whole body weight.

In the human foot, which is purely for locomotive function, one of the greatest changes that has taken place is incorporation of the first metatarsal and its digit into the general mass of the foot. This means that the great toe with its metatarsal falls parallel to the others and so differences in their relative lengths determine where the stresses will be thrown in a way that they do not when the first toe is independent of the rest of the foot as in the anthropoids.

Under conditions of civilized life movements of the foot became stereotyped and quite unlike the variable movements of the anthropoids. A factor which tends to enhance the stereotyping of the foot movements is the levelling of all surfaces with which the foot comes in contact, roads, pavements and even more so by the adoption of footwear, the rigid sole of which constitutes an artificial level for the foot which we carry with us as an armored tank carries its own track to enable it to progress over rough ground. The human foot is in the process of evolution and has not yet attained its ultimate perfect adaptation for this purpose.

The foot best adapted to the demands of civilized life is one in which the first metatarsal is equal to or longer than the second and third and is adequately stabilized at its base. If the first metatarsal is unstable at the proximal end or shorter than the second and third, the strain falls on the weaker bones. Callosities form under their heads and other secondary effects arise, including clawing and hammer toes.

The Sesamoid mechanism of the first metatarsal allows the head to rise with undue friction to the take-off position. When the weight falls on the second and third there is no such mechanism and so the heads are rolled forward pushing in front of them the fibro-fatty pads on which the callosities develop, at the same time the proximal phalanx is forced into the dorsi-flexion by the forward displacement of the metatarsal heads and fibro-fatty

pads.

The question whether the arch (or better triangle) is to be thought of as functional or architectural is debatable. I believe it is a permanent architectural character resulting from the backward and downward extension of the os calcis which was determined by the upright posture. The human foot is designed to take the main stresses and strains, both static and dynamic on the posterior half of the foot and so any use which throws these forces on the forepart of the foot leads to considerable disability and also to many secondary deformities.

The form of the foot can be altered by restricting forces cannot be denied. The Chinese ladies' feet of a previous generation is evidence. It has been customary to place the blame for almost all disabilities and deformities upon footwear. Let us not forget the evolutionary factors in getting at the true origin of many foot troubles.

Footwear of some type has only been used about 4000 years. Some museums have various types of footwear which are 3500 to 4000 years old. The simplest foot protector is a sandal which consists of a sole attached to the foot usually by leather thongs. The use of this can be traced back to a very early period and the sandal of plaited grass, palm fronds, leather or other material continues to be the most common foot covering among oriental races. Where climate demanded greater protection for the foot the primitive races shaped a rude shoe out of a single piece of untanned hide; this was laced with a thong and so made a complete covering. Out of these two elements—sole without upper and upper without sole arose the perfected shoe and boot of today, consisting of a combination of both.

The simplest foot covering largely used throughout Europe is the sabot, made from a single piece of wood roughly cut into shoe form. Analogous to this is the clog of the midland counties of England. Clogs, known also as pattens, are wooden soles to which shoe or boot uppers are attached.

The most common foot ailments: foot strain and pain, hammer toes, plantar callosities, bunions, accessory scaphoids, marcher's foot or fractures of the metatarsals which are caused by constant weight bearing under heavy loads. They are seen in laborers who lift heavy loads and occasionally in obese women. Other common conditions: plantar warts, neuromas between metatarsal heads. I believe the most common causes of foot pain are (1) Faulty posture which causes inward rotation of the tibia, sagging of the astragalus leaving the forefoot pointed outward. (2) General debility from sickness and worry, the feet expressing by pain the relaxed fatigued condition. (3) Muscular imbalance between inner and outer groups or a contracted heel cord which does not allow the foot to be dorsally flexed at a right angle with the knee in extension.

(4) Change of occupation as from sitting to a standing one. (5) Rapid increase in weight. (6) The modern shoe which tends to throw the forefoot outward and weakens the protecting muscles and ligaments by cramping the foot, especially the metatarsal region.

Findings in patients who have painful feet: (1) tight heel cords, (2) short first metatarsals, (3) chronic strain due to pronation or eversion of the foot, (4) exostosis over dorsum of the foot, especially the region of the first metatarsal first cuneiform joint, (5) a majority of these patients give a history of having had difficulty in being properly fitted with shoes, (6) deformities caused by congenital club feet and under this heading are placed not only the equinovarus and varus deformities but also the pes cavus type which are frequently unrecognized and untreated until patients are adults, (7) old cases of anterior poliomyelitis or other nerve lesions, particularly gunshot wounds which have damaged the external peroneal or other nerves of the leg, (8) hemiplegias who have developed marked contractures, particularly of the heel cord, (9) pain and tenderness of the scaphoids or tarso-navicular, (10) cases of foot strain if due to obesity must be handled from a general standpoint, that is, thorough work-up by an internist and reduction of weight if at all possible.

Treatment (1) tight heel cords. These patients should never be allowed to wear low heels. The height advised is at least 1½ inches or higher and exercises for stretching heel cords and treatments by a well trained physiotherapist. If these patients do not respond to conservative treatment lengthening of the heel cord is advised, and in selected cases neurectomy of the internal popliteal nerve. (2) Treatment of short first metatarsals—a support which is worn in the shoe and lifts the first metatarsal. These are known as Morton pads or supports, also transverse bars are frequently used. (3) Most of these cases can be taken care of by putting 3/16 inch to 1/4 inch wedge on medial side of sole and heel. It is always advisable for the shoe to have stiff counters. (4) For exostoses on dorsum of foot a blucher type of shoe with sponge rubber sewed to the tongue will relieve the irritation and in only few cases is it necessary to excise the exostoses. (5) Improperly fitted shoes—unfortunately most shoe salesmen do not know anything about anatomy or physiology of the foot and generally only one measurement is taken, that is from the heel to the toe. An additional measurement should always be done, that is from the heel to the first metatarsal phalangeal joint. Whichever is longer is the size that should be put on the foot. (6) The old congenital club foot can only be adequately cared for by lengthening of the heel cord, plantar fasciotomies and/or triple arthrodesis. Even the pes cavus, particularly in heavy people, may require triple arthrodesis and these are about the only cases in which I treat conservatively.

with metal foot plates. (7) Repair of the nerve is always attempted but in many cases such a large portion of the nerve is shot away that it may at times be necessary to try a nerve graft, usually resulting in very poor results. Within the past year and a half a graft approximately $6\frac{1}{2}$ inches long was sutured in place on an external peroneal nerve. This patient has gotten almost complete sensory return but has had no motor function after a period of 17 months. However, it is generally necessary to do not only triple arthrodesis but in many cases a stabilization or fusion of the ankle joint to avoid life long use of a brace. (8) These are always treated in the same way as the old cases of anterior poliomyelitis. (9) Most of these cases have accessory scaphoids and get almost complete relief by excision of the accessory scaphoid followed by properly fitted shoes. Treatment of marcher's foot—weight lifting or carrying of heavy loads should not be done and definite rest periods each day and if possible keep patients off their feet by the aid of crutches for as long as ten days supported by stiff leather sole shoes. Nearly all of these cases have some healing when seen.

Painful toes, particularly hammer toes. The method that I like best for the treatment of this condition is excision of the proximal phalanx or the proximal two-thirds of the first phalanx and webbing of this toe to the second or third as the case may be. Plantar callosities are generally caused by the pushing forward of the fat pad and narrow shoes. These patients may have the large thick callosities treated by chiropodists in addition to metatarsal sponge rubber supports. After 6 to 8 months with the sponge rubber supports and shoes which are large enough, they will gradually disappear. Bunions—excision of the large exostosis, division of the abductor hallucis tendon from the base of the first phalanx of the great toe, over-correction of the deformity and plaster splint for $2-2\frac{1}{2}$ weeks followed by properly fitted shoes. A great many of the patients with bunions

also require the Morton type of support. Plantar warts: In my mind the treatment of choice is surgical excision. Other methods used for treatment of these warts are radium and x-ray. Neuromas are nearly always diagnosed metatarsalgia but it is interesting to note that nearly all of these patients with the latter condition give a history of occasional sharp pain which is relieved by removal of the shoe for only a minute or two. The outstanding diagnostic point of the latter is point tenderness on the dorsal aspect or between the webbing of the toes in painful region.

At least 90 per cent of all the patients I see who have various pains of the feet are due to shoes which are at least a size and a half to two sizes too short and one to two widths too narrow. Most of these patients should certainly have x-rays to help to determine whether there is an unstable first tarso-metatarsal joint or whether the first metatarsal is shorter than the second. Some of the conditions which have been intentionally not mentioned are the atrophic arthritics, patients with gout, diabetes, neurovascular spasm, Tricophyton infections, etc., as this would cover too great a field and time would not permit a discussion of all the problems connected with disabilities of the foot. The ideal type of shoe is a broad toe, straight inner border, stiff leather sole and Thomas type of heel, and in addition to the shoe many of these patients will respond to treatment with definite rest periods, elevation of the lower extremities, thorough cleansing with soap and water and contrast baths. Care of the feet requires care of the shoes by use of shoe trees, permitting the inner lining to dry thoroughly when the feet perspire freely and avoid wearing of shoes when wet. Saddle soap for cleansing of shoes to make them pliable and to prevent cracking of the soles as well as the uppers.

Treatment of painful feet in many cases requires collaboration of the internist, dermatologist, chiropodist and orthopedist with all this far too many patients still have disabilities of the feet.

President's Address

(Delivered at Myrtle Beach, May 1, 1946)

W. Thomas Brockman, M.D., President
South Carolina Medical Association,
Greenville, South Carolina.
Fellow Members of the South Carolina Medical Association.

When I first started making preparations for today's little talk, I was reminded of the Biblical story of the talents, and of the accounting which each servant made to his master of the use he had made of those talents.

Two years ago the members of this Association turned over to me—in the form of the presidency-elect of your organization—certain valuable properties which I could use as I saw fit in support to the president. Like one servant in the Biblical story, I could have buried those properties, and at the time of accounting unearthed them and returned them to you. Or, like the servant, I could choose to invest them in the belief that they would bring increase which would be to our mutual advantage.

Today I bring you a report of my two-year stewardship, and when you have heard it, I hope that your command will be "well done, good and faithful servant."

Even before my selection to the presidency-elect of the South Carolina Medical Association, my local society—the Greenville County Association—recognized the strides which were being taken toward some form of state medical program, and while we recognized the vast and unfilled need for more medical services for the people of America, we could also see the great harm which would be done to our nation if a state or socialistic form of medical care program was inaugurated. There must be, we reasoned, some middle ground which would permit more people to have the medical services they needed or to permit them to pay for services which they were unable to obtain except through charity. Some solution to the problem other than the forced regimentation of the medical profession and all its users.

In our search for such a method, we investigated the various voluntary medical care programs, and in them we believe we found the answer.

As your president-elect, I brought to you the message of the Blue Cross, and I am honored to think that many of you, like myself, believe that in this or some similar program, we may have found the answer to our health problem and at the same time our answer to the Murray-Wagner-Dingell Bill.

You have led me to believe that the Blue Cross Chapter which we organized at Greenville five years ago may become either the mother chapter for a much expanded voluntary health program, or that my County's chapter may be absorbed into a more powerful State group. I believe that the time is now ripe for this Association to throw all of its weight and influence behind its Blue Cross effort.

May I digress for just a moment to remind you of some of the reasons for such action, what it can mean to the people of South Carolina, and what the alternatives may be if you failed to direct such action?

Perhaps we should mention the alternatives first. I am sure that all of you will agree with me that in the post-war days and months ahead of us, this nation and this State is not going to be content to adopt a course of business as usual. The people of America have been seriously alarmed by the high rejection rate disclosed by our experience with Selective Service, they have awakened to the fact that rural areas may be unhealthy slums instead of the health-spots of the country. They are especially alarmed by the unhealthy conditions which have been shown to exist in the South, and are determined to eradicate them somehow.

As members of the medical profession we are in complete agreement with this desire to make our nation more healthy. We are sincere when we state that we have done all we can do to ameliorate this situation both as individuals and as the South Carolina Medical Association.

But we are not ready to admit, with Senators Murray and Wagner and Representative Dingell, that our attempts have all been failures and that the problem is so big that only the big stick of federal government regimentation can solve it. That, gentlemen, is the alternative. We solve the problem ourselves—or at least make a reasonable earnest beginning toward such a solution—or the federal government will step into the picture to do the job for us.

Regimentation deprives the average mind of all chance of growth and the ambitious mentality of all hopes of fruition. Simultaneously it diminishes that superb efficiency which appears when a person responds to the normal incentives.

Have you gentlemen thoroughly examined the so-called Medical Care Bill introduced by Congressmen Wagner - Murray and Dingell? On the surface its wording seems innocuous enough, and many physicians have become convinced that it is a painless panacea for many of our medical misfortunes. Yet please note and determine for yourself whether you want to be placed under a plan which:

1. Place in the hands of the Surgeon General the power to make and publish all rules and regulations relative to the administration of the Federal medical and hospitalization benefits.

2. The determination of qualification for designating specialists.

3. The establishment of fee schedules for all medical services.

4. The setting up of standards to apply to all participating hospitals and clinics.

5. The determination of the number of potential patients for whom a physician may provide services.

6. Determination of methods to be used to pay for medical and hospital services, the hiring of doctors on a salary basis if desired.

Would you be willing to operate under such a set of rules and regulations, you gentlemen who have always been free to use your own judgments on all such matters? Do you really believe that someone in Washington can direct from his desk there the way you should operate your practice here in South Carolina?

And even if you were willing to accept such regimentation for both yourselves and your patients, would you be willing to saddle your family and your friends with the enormous debt which such a program—operated in the usual Washington inefficiency—would cost, but most of them are in agreement that it will range somewhere upward from ten to twenty billions of dollars:

But I fear that my talk grows tiresome as I repeat the same pleas which I—and many other doctors—have already made to defeat this Bill. Yet I tell you the only way we can defeat it is to substitute something which has the promise of more or better services than the Wagner-Murray-Dingell Bill.

In my own humble opinion we have that in our voluntary health programs such as the Blue Cross, wherein each doctor is allowed free choice of patients, and the patients free choice of participating doctors, wherein provisions are made for payment on the basis of service provided, and wherein an ambitious doctor can rise above the lot which would be under a regimented federal medical care program.

But enough for the moment on this subject. As a steward I have other reports to make if you are to judge the work of my entire administration.

One piece of work of which I am proud to say I had some small part in inaugurating is on the Basic Science Law. While no actual legislation has yet been initiated in this field, I believe that the educational groundwork has been developed to the point where we are almost ready to urge some such law. Encouragement has come to me on my efforts from almost every possible source except the cults and this is understandable, as were their ugly disparaging letters. I believe, and many of you have given me to understand that you, too, believe, that organized medicine is ready and able to stand on its own legs, and that these cults should do the same. I urge you to now take formal action on this matter, and urge our legislative committee to see that some such measure as you believe most fitting is brought before the next session of our Legislature.

As a third section to my report of stewardship, I would like to call to your attention our Association's work in advocating that the Veterans Administration request State and County Societies to formulate plans to treat veterans with service-connected disabilities in local general hospital using qualified physicians who are members of the County Societies. I have seen my own Greenville County Society complete one such agreement with the Veterans Administration

in Washington, D. C., and with this as a pattern have suggested that it be broadened into a State program of our Society, or that other County Associations follow this example.

There is a somewhat hidden but at the same time important reason why we should do this. It is another blow at Socialized Medicine as prescribed in the Wagner-Murray-Dingell Bill. The Bill calls for something similar to this, and we can draw the teeth of that portion of the Bill if we have anticipated the need and can prove that we are already giving veterans this service.

Except for these three major items in my accounting, I have had the pleasure of performing or assisting in the performance of many smaller or less essential incidentals connected with my office. These have included addresses made to many of the County Societies represented here today, some of them to explain the Blue Cross Program and others to combat the rising clamor of the Wagner-Murray-Dingell Bill by those who are unfamiliar with the dynamite it contains. I have attended many legislative committee hearings on various bills which have interested us in the Legislature, or in our own sessions planning how to best secure the legislation we know is needed. In this category, this year we have worked for the adoption of a hospital commission Act to conform to the Hill-Burton Bill; and I can report to you that such an Act has been passed.

As your representative, I had the pleasure of attending two testimonial or honorary parties given during the past year. The first, was that fine tribute paid to Dr. C. Fred Williams by his colleagues and associates. The second, was of recent days when fifteen hundred to two thousand patients, babies and friends did the beautiful, the inspiring thing of honoring one of Greenville's family doctors, Dr. Fletcher Jordan. Such episodes as the above two occasions are not only good for the worthy recipients of these honors, it is good for the laity, the public and most of all "Organized Medicine." Somehow, I am inclined to the belief that many more of our number should be likewise honored for faithful service. It will stimulate the younger men and inspire them to strive to obtain a similar love and affection. And too, it is good for us to counter propaganda the Wagner-Murray-Dingell Bill with such overwhelming evidence of public confidence and esteem.

I would like first to pay especial tribute to Dr. James McLeod for his able and valiant leadership of a Medical College Expansion Program through our Legislature. As you know this was brought to a successful conclusion, and Dr. McLeod's efforts have resulted in the passage of a million and a half appropriation which will be matched by Federal Funds.

Another efficient, hard working, and seldom recognized member of our staff is Mr. M. L. Meadors, our Public Relations Officer, who, each day, more and more justifies the wisdom of my predecessors in securing the services of such a tireless worker. It is an old saying that physicians frequently need the

services of a good lawyer, because they are too good-hearted, trusting or innocent to defend themselves from the unscrupulous members of society. In Mr. Meadors we have not only an excellent Public Relations officer but a well-read lawyer as well who has served in both capacities.

I think it scarcely necessary to mention the great services which have been performed by our Secretary. All of you are familiar with them and his tireless efforts in our behalf. I believe that he is one of the outstanding secretaries and editors in our National Organization; and have been assured by many from outside the State that he had that reputation with them.

In conclusion, let me add another group to the long list of people who have assisted me in my stewardship and to whom should go all credit for any successes we might have made during these past two years. I would like to mention by name, however, and to assure them of my unending gratitude,

Drs. Frank Cain and Robert Durham, and all the members of the Council. I would like to pay tribute to the Greenville County Society for its whole-hearted cooperation and deep interest in the success of this meeting and special mention be given Dr. J. D. Guess for his valiant service as Chairman Program Committee and for his sympathetic understanding of my State problems. Dr. Jack Parker for his legislative effort in behalf of the Hospital Commission. Dr. T. G. Goldsmith for his untiring work as Chairman Entertainment Committee. Dr. Charles N. Wyatt for a fine service in working out the Veterans Service connected hospitalization and to Dr. Mordecai Nachman, President Greenville Society for every day interest and cooperation and sacrifice if need be for the success of our State Program.

Gentlemen: I thank you for your kind attention, and the honor which you have bestowed upon me for this past two years, and your cooperation in making those two years the success which I believe they were.

ANNUAL MEETING SOUTH CAROLINA PUBLIC HEALTH ASSO.

Myrtle Beach, S. C.

May 27, 28, 29, 1946

Monday, May 27—9:30 A.M.

Registration

Call to Order by President, M. J. Boggs, Jr., M.D.

Invocation

Welcome

O. C. Calloway, Mayor

Myrtle Beach, S. C.

Address

Ben F. Wyman, M.D., State Health Officer

Columbia, S. C.

The Future of Medicine

James McLeod, M.D., President

South Carolina Medical Association

Public Health Administration from a National Level

W. K. Sharp, Jr., Medical Director

U. S. Public Health Service District No. 2

Richmond, Va.

Presidential Address

M. J. Boggs, Jr., M.D., Director

Abbeville County Health Department

Public Health Education

Eunice N. Tylor, Ph.D.

Associate Professor of Health Education

University of North Carolina

Address

The Honorable Ransome J. Williams

Governor of South Carolina

Appointment of Committees

Adjournment

Tuesday, May 28—9:30 A.M.

Parasitic Diseases with Special Reference to Malaria

H. W. Brown, M.D., Professor of Parasitology

Columbia University School of Public Health

Influence of Antepartum Guidance on Intrapartum and Postpartum Events

J. Dechard Guess, M.D., Obstetrician and Gynecologist, Greenville, S. C.

Quantitative Tests for Syphilis with Special Reference to the Mazzini Tests

J. F. Mahoney, Medical Director (Arnold)

Veneral Disease Research Laboratory

U. S. Marine Hospital, Staten Island, N. Y.

Recent Developments in Field Training Programs and

Trends in the Field of Environmental Sanitation

Ellis S. Tisdale, Senior Sanitary Engineer

Acting Chief, Training and Education Division

U. S. Public Health Service, Atlanta, Ga.

Public Health Nursing

Miss Ruth G. Taylor, Director

Nursing Units, Children's Bureau

U. S. Department of Labor

Phases of Rodent and Typhus Control Affecting the

Generalized Sanitation Program

George S. Bote, Typhus Consultant

Bureau of Sanitary Engineering

Florida State Board of Health

Public Health Nursing

Mrs. Laurene C. Fisher, Director

Bureau of Public Health Nursing

State of West Virginia Department of Health

Wednesday, May 29

Report of Activities, Reorganization of Vital Statistics of Japan

Forrest Linder, Assistant to the Chief

Vital Statistics Division, Bureau of the Census

Washington, D. C.

The Economics of Tuberculosis Control

Norvin C. Kiefer, Surgeon, Office of the Chief

Tuberculosis Control Division

U. S. Public Health Service, Washington, D. C.

Organization and Plan of Infantile Paralysis Chapters in South Carolina

Julian S. Martin, State Representative

National Foundation for Infantile Paralysis

Columbia, S. C.

The Program of the National Foundation for Epidemic Emergency and Year Round Medical Care of Infantile Paralysis

Hart Van Riper, M.D., Assistant Medical Director

National Foundation for Infantile Paralysis

New York City

The Modern Treatment of Infantile Paralysis

Robert L. Bennett, M.D.

Director of Physical Medicine

Georgia Warm Springs Foundation

Warm Springs, Ga.

Business Session

Election of Officers

Adjournment

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)
Subscription Price

Florence, S. C.
\$3.00 per Year

MAY, 1946

OUR NEW PRESIDENT

At the annual meeting of the South Carolina Medical Association held at Myrtle Beach, Dr. James McLeod of Florence was inducted into office as President for the coming year.

A native of Florence, Dr. McLeod received his academic training at Davidson College and at the University of North Carolina. He then attended Cornell Medical School from which institution he received his degree of Doctor of Medicine. Following a two years' internship in surgery at Bellevue Hospital (New York), Dr. McLeod returned to Florence to engage in the practice of surgery with his father, the late Dr. F. H. McLeod.

Through the years, Dr. McLeod has established an enviable position in scientific medicine. His services as a surgeon and his advice as a consultant are widely sought. Following in the footsteps of his father, he assumed the superintendency of the McLeod Infirmary and has not only carried on the traditions of that institution but has enlarged its usefulness and efficiency until it now ranks as one of the better smaller medical centers in the South.

Dr. McLeod has also given freely of his time and effort to the work of the S. C. Medical Association. As President of his county and district societies, as a member of Council, and as President-Elect he has served efficiently and effectively. As Chairman of the Special Committee of Seventeen, it was largely due to his efforts that legislation was passed at the last session of the General Assembly for the much needed expansion of the Medical College in Charleston.

As is true of many outstanding physicians, Dr. McLeod has not confined his energies to the field of medicine alone but has entered into the civic life of his community and of his state. The people of Florence have called upon him repeatedly for advice and leadership in civic enterprises. Only recently he led a successful campaign for raising funds with which to build a large memorial stadium. Other sections of the state have also called upon Dr.

McLeod and he is in constant demand as a speaker and adviser.

Possessing as he does, intelligence, ability, aggressiveness, and integrity, Dr. McLeod is well qualified to lead our Association during the coming year.

OUR PRESIDENT-ELECT

Olin Burnham Chamberlain, M. D., President-elect of the South Carolina Medical Association, was born in Charleston June 25, 1892. After attending the public and high schools of the city, he entered The College of Charleston, graduating in 1914. While at this institution he majored in biology and was the recipient of a Boyce scholarship, the Junior Medal, and second honors in his senior year. Proceeding to the Medical College of the State of South Carolina, he graduated as first honor man in 1918, receiving the College Cup for the best scholastic work during the four years, and adding to his honors the John L. Dawson Cup and the Blease Medal.

For a short time he was Chief Resident Physician at Roper Hospital, after being Resident Physician at the Philadelphia General Hospital. Entering general practice in Charleston in 1920, after five years he confined his work to internal medicine, with special interest in nervous and mental diseases. While in practice, he was also the acting professor of biology at The College of Charleston, and later, from 1929 to 1934, was professor of psychology in that school. Passing through the lower grades in the faculty, he became assistant professor of medicine at the Medical College in 1929, (part time) associate professor in 1935, and has just recently become full time professor of neuropsychiatry in the medical school. He has also been a visiting physician on the nervous and mental service at Roper Hospital since 1924.

Dr. Chamberlain took postgraduate work at the National Hospital for The Paralyzed and Epileptic, Queen's Square, London, in 1929, and later at Harvard University Medical School in 1934. He was first an associate, and later, a fellow of the American College of Physicians, being at the same time certi-

fied by the American Board of Internal Medicine.

On June 15, 1942 he entered the army as a major, and was assigned as assistant chief of the neuropsychiatric service at La Garde General Hospital, New Orleans, later, in September 1942, becoming chief of the neuropsychiatric service at Bushnell General Hospital, Brigham City, Utah. On March 23, 1943, he received his promotion as lieutenant-colonel, and on July 17, 1945 became colonel. He was separated from active service December 5, 1945.

PEDIATRIC SEMINAR

Elsewhere in this issue will be found the announcement of the Pediatric Seminar at Saluda, N. C. This Seminar, which is held annually, has served practicing physicians from every southern state and is recognized throughout the nation as one of the finest intensive courses in pediatrics available to the general practitioner.

Under the leadership of Dr. D. L. Smith of Spartanburg, the "daddy" of the Seminar and its Registrar, and Dr. Sam Ravenel of Greensboro, the Dean—outstanding pediatricians from the South gather for two weeks to discuss the everyday problems of diseases of children. Ample time is allowed for the answering of questions.

We know of no better way for the general practitioner—particularly for the one returning from military service—to bring himself up to date in the field of pediatrics than to attend this Seminar. Those who so desire should communicate with Dr. Smith.

STUDY OF CHILD HEALTH SERVICES

In view of present agitation concerning plans for medical care, it seems very fitting that the pediatricians in South Carolina and throughout the United States should have decided at this time to assume their share of responsibility for the development of a sound program of child care based on factual knowledge.

Accepting the challenge to evaluate activities and make plans in its own field, the American Academy of Pediatrics has launched a nation-wide Study of Child Health Services as a first step toward the achievement of its post-war objective, "to make available to all mothers and children in the U. S. all essential preventive, diagnostic and curative medical services of high quality which, used in cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

The Study is being organized on a State basis with the State Chairmen of the Academy serving as coordinators for the individual State programs. A test Study has been completed in our neighbor State, North Carolina, as a dress rehearsal for other States. The cooperation received, as shown by the very grati-

fying returns from the pilot state, indicates that interest in the Study is keen and that pediatricians and physicians are fully aware of the importance of the project to themselves and their communities.

South Carolina has already undertaken its share of responsibility under the able direction of Dr. William Weston, Jr., State Academy Chairman for the Study, and Dr. Henry W. Moore, Executive Secretary for the Study in South Carolina. Preparations for the collection of the necessary data are well underway and approval of the Study has been vouchsafed by many groups within the State.

Information for the Study will be sought from pediatricians, physicians and dentists in private practice; from hospitals and other institutions; from official and voluntary health agencies; and from medical schools and colleges. Basic data will thus be obtained on all aspects of medical and health care for children. These data will be made available to all interested groups as a sound basis on which improvements in community facilities and services can be developed where needed.

The pediatricians of South Carolina have committed themselves to do a thorough job of fact-finding in order that we may learn exactly where we now stand in providing essential medical care for our children. The collection of the vast amount of data required represents a tremendous undertaking; an undertaking which concerns every physician and every person who contributes to our child care program. Special one-page schedules have been carefully prepared for distribution to physicians engaged in private practice in this State in order that they may contribute their share of information to the Study. The questions included have been reduced to an essential minimum and the information requested can be supplied only by the physician himself. The contribution of physicians is of major importance to the successful completion of the Study in South Carolina and in the rest of the country. The evident need for such a Study at this time warrants the full cooperation of every individual approached in the process of its completion.

PROCUREMENT AND ASSIGNMENT

On March 31 the Procurement and Assignment Service of South Carolina for Physicians came to an official close. May I take this means of thanking you for the privilege of having a part in this service. For the past five years, with the help and advice of the officers and council of the Association, I have endeavored to the best of my ability to discharge the duties which this service imposed. I have no doubt but that mistakes were made. This is true of every human endeavor. Nevertheless, I do claim that this organization has been run on an honest basis. It has been our constant endeavor to determine each case

according to its merits. No case, to my knowledge, has been handled or allowed to be influenced by politics or local jealousies.

I deeply appreciate the fine spirit of loyalty and devotion manifested by the doctors who were selected to serve in the Armed Forces. Just as truly do we recognize the tremendous service rendered by those who remained to carry on the ever increasing duties at home.

I feel very deeply, and want to say so, that the benefits I received from happy associations with our doctors have far outweighed the inconveniences and extra hours of work connected with the duties of this office.

The South Carolina Medical Association has certainly been most kind to me. You have given me the privilege of serving in various capacities. I can truthfully say that I have greatly enjoyed and been helped by every service I have been able to render.

It is now my wish, not to retire, but to return to the Infantry and carry on as best I may for the good of the doctors of South Carolina, a wonderfully fine bunch of fellows.

With sincere appreciation and thanks.

W. L. PRESSLY, M. D.

THE ANNUAL POSTGRADUATE SEMINAR OF THE ALUMNI ASSOCIATION WILL BE HELD IN CHARLESTON NOV. 5, 6, and 7, 1946

Your committees earnestly request your early suggestions as to speakers and as to the general arrangement of the program. Please write at once to Dr. D. Strother Pope, Columbia, S. C., or to the local committee in Charleston, in care of Dr. J. I. Waring, 82 Rutledge Avenue, Zone 6, as invitations to speakers must be sent out within the next few weeks.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

WHAT LABOR EXPECTS FROM MEDICINE

(Address delivered by Nelson H. Cruickshank, Director Social Insurance Activities, American Federation of Labor, Washington, D. C., at the National Conference on Medical Service, Chicago, Ill., Feb. 10, 1946. Reprinted from Connecticut State Medical Journal, April, 1946.)

In all sincerity I am glad to accept the invitation of your President, Dr. Palmer, to speak on this subject under the terms of an open forum. While we have a point of view we recognize the sincerity of those who hold differing opinions.

In the spirit of an open forum I shall present the point of view of labor as vigorously and in as straight forward a manner as I know how. I think that is what you want me to do. I have come a considerable distance to speak to this group and I know many of you have left busy offices and demanding practices in order to be here. That can only be justified if we come squarely to grips with the problems presented by our subject. While I shall present our position without reservation, in the spirit of free exchange of ideas, I shall endeavor to bear in mind that on any point I may be wrong. May I ask you too to approach this problem in the same spirit, remembering that even the *ex cathedra* pronouncements of the American Medical Association may on some points be in error.

The interest of organized labor in health problems dates back over many years. Working people know from hard experience how surely ill health under-

mines security. Consequently they have long been concerned with the health hazards of the places in which they work, of the communities in which they live, and of themselves as human beings subject to illness, disability and premature death.

Like other people, workers want good health for their families as well as for themselves. They want, therefore, to know that adequate, modern medical care will be available to them and their families when it is needed. Increasingly, workers are coming to realize that the services of the doctor, hospital, dentist, nurse and laboratory must find a place in the family budget before a family can count itself secure.

I should like to make clear at the outset that the American Federation of Labor does not think of health insurance or any of the social insurances as a substitute for jobs and wages. American workers will in the future as in the past rely for their security mainly on steady jobs at good wages. Social insurance, however, is like a net spread under the aerial trapeze performers we see at the circus. It does not impede the freedom of motion nor detract from the brilliance of individual performance; it simply provides that in case something goes wrong the performer doesn't necessarily break his neck. Social insurance is the method chosen by workers to underwrite cooperatively the risks that are a part of modern industrial society. They recognize that illness and accidents are among the greater of those risks.

Nor do I intend to minimize the importance of the satisfying and healthful aspects of the job; good

housing, adequate nutrition, or any of the environmental factors which contribute toward good health. To listen to some of the opponents of health insurance, however, you might conclude that if workers had these things they would not need doctors or nurses or hospitals. They should know better, especially the doctors among them. Workers have more faith in the value of the services furnished by the medical profession than some members of the profession would seem to have. In a layman's manner, workers know what the physicians in this audience could tell them in more scientific terms. They know that delay in getting medical care in many cases means the difference between life and death or between disablement and recovery. They know how important it may be for the family doctor to be able to call in specialists or to utilize modern diagnostic aids—how important and how costly. They have been hearing for years about the great progress of scientific medicine, especially when practiced by well organized groups; they have been reading of the wonderful medical advances made during the war. They intend now to include this modern medical care in their standard of living.

When I was asked by the secretary of this Conference to speak on the subject "What Labor Expects from Medicine" I hoped I would be able to speak with some certainty. That hope has been fulfilled during this past week. I have just come from a four-day conference in St. Paul, Minnesota, where representatives of all branches of organized labor and farm representatives from seven states sat down with experts in the field of medicine and public health in a serious analysis of the health needs of our country. They were so firm in their convictions and so earnest in their conclusions that now I have an increased certainty about what people who are squarely up against the health needs of workers expect from medicine.

It is quite clear first of all that the workers of America have reached the conclusion that, if they want medical care in the family budget, they must get away from the present catastrophe basis of paying for it, and get on to a budget basis. To labor, the argument for health insurance is as simple—and as irrefutable—as that. The family or individual need for medical care is too unpredictable, the costs of modern medical care too variable, to make possible individual family budgeting. Joint budgeting, through social insurance, seems to us the obvious answer. Voluntary insurance is fine for those individuals who can afford it and can get it. But the inclusive coverage provided by compulsory social insurance is the only practical answer for the millions.

Fortunately, I do not have to discuss labor's interest in health insurance in vague and general terms. The Wagner-Murray-Dingell bill of 1945 (Senate bill 1050) offers the kind of a health program which labor wants and believes to be essential to the future

welfare of this country. I do not propose to discuss the details of the bill, but I shall comment briefly on a few of the major features which are responsible for labor's support of the measure.

Right here I should like to inject that among the first things that labor expects of medicine is that its practitioners be scientific. Workers do not question that in the main doctors are objective and scientific in the diagnosis of disease affecting individual patients. But they are not so sure that the professions so scientific in its analysis of social and economic problems. It is in fact a source of constant amazement that men trained in the scientific tradition can in questions of medical economics accept so readily the "pink pills for pale people" and the other social and economic nostrums peddled in the *Journal of the American Medical Association*. I have spoken before a number of doctors' groups, for example, about the Wagner-Murray-Dingell bill, and though most of their members have strong feelings about the bill most of them have never read it. I have even appeared in forums where doctors openly and heatedly opposed this measure, at the same time confessing that their opinions were based only on second hand acquaintance with its provisions. Now that's just not being scientific. I'm sure that none of you would prescribe for a patient on the basis of hearsay evidence. Labor pleads with the medical profession to examine our sick society, diagnose its ills and prescribe its remedies in the truly scientific spirit that is the glory of the profession.

As I have indicated, prepayment of the costs of medical care through small, regular payroll deductions seems to us economically sound. Labor is more than willing to leave to competent professional judgment all matters having to do with the professional aspects of medical practice. How the patient shall pay for the service he receives, however, is not one of the strictly professional aspects of medicine. On this subject, there are others more expert and at least as competent to speak as the doctor.

Let's apply some plain common sense to these discussions of the doctor-patient relationship: In the past few years there's been a great deal of pure buncombe put forth on this subject and I suspect the months ahead will see even more. I say this because most of the talk while purportedly in behalf of the doctor and the patient has expressed the point of view of only one of the parties in this two party relationship; namely, the doctors'—though not that of all doctors. The efforts of certain entrenched interests of the medical profession to preserve and protect the welfare of American labor is all too suggestive of the efforts of some employers to "Protect" their workers from labor unions. That memory is too fresh in the minds of American workers for them to be taken in by it. Certainly, we wish to leave the professional aspects of medical care to the doctors. That, we would call their "jurisdiction." But when

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it comes to the business of payment and the method of payment: That's a two-party affair and we're the other party. At least we represent a significant proportion of the recipients of medical care.

The alternatives to health insurance are charity care, the loan shark and continued neglect of health needs and opportunities. Labor wants none of these; we've had them too long and they are too painful and expensive. What workers do want and are determined to have is an opportunity to earn, through their own contributions, adequate medical care for themselves and their families to which they will be entitled as a matter of right when the need for care arises. That's why we hold to the contributory principle in social insurance.

The only direct change which the health insurance provisions of the Wagner-Murray-Dingell bill would make in the present methods of distributing medical services would be a change in the methods of paying for such services. All licensed physicians are guaranteed the right to enter the insurance system—or stay out—as they choose. Dentists and nurses and hospitals have similar guarantees. Free choice of a general practitioner is assured, and a family may change doctors if it wishes. The guarantees of non-interference in the professional aspects of medical practice and in the operation of hospitals are even stronger in the 1945 bill than they were in the 1943 Wagner-Murray-Dingell bill. These provisions were strengthened and clarified in response to the specified request of the American Federation of Labor, backed up by the opinion of liberal doctors.

We are convinced that health insurance would bring an improvement in the relation between doctor and patient, by removing the financial barrier between them. It would make it possible for the great majority of doctors to practice better medicine than they can practice today, simply because no insured patient would be barred by lack of current income from getting necessary laboratory, hospital or specialist care. We applaud the inclusion of dental, the home nursing benefits, even though it may be necessary for lack of personnel to limit such benefits at the outset.

Working people have long experienced the evils of cheap medical care, obtained through certain types of contract practice. We recognize that the doctor, as well as the worker, is worthy of his hire. It seems to us that S.1050 protects the physicians and that there should be money enough to provide them with incomes which will be at least as good, and generally better, than the incomes earned by doctors now. This applies to general practitioners and to specialists. To be sure, insurance practice won't pay all doctors incomes as high as those earned by the small percentage of physicians who earn very large amounts. But it can pay every doctor a fair—and even a generous—reimbursement for insurance ser-

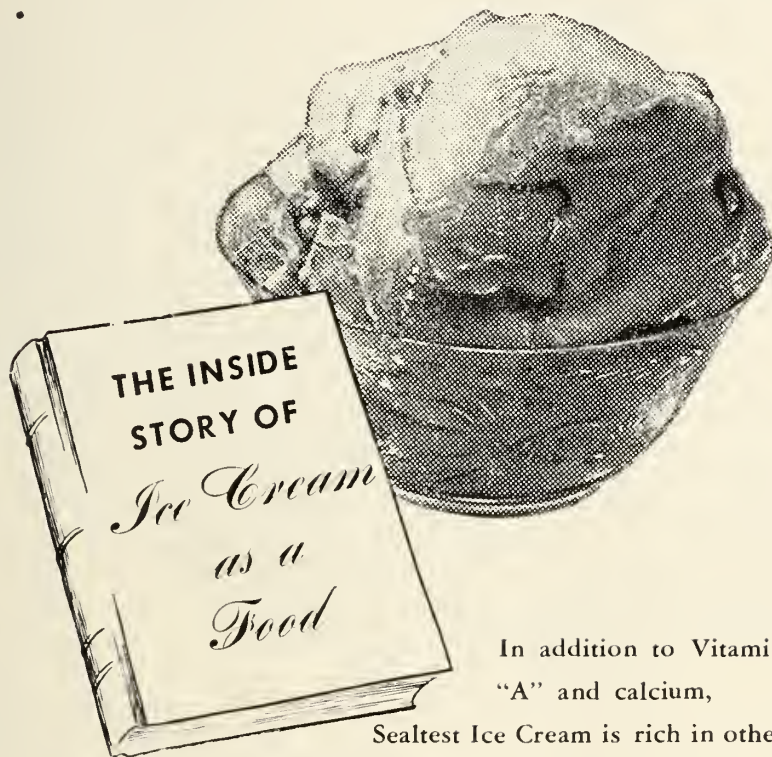
vices. The high-income doctor, serving the rich, can keep right on with that as a non insurance practice.

We believe that just as we are able to do better work if we are well paid and have assurance that work and pay will continue, so will the doctor be able to carry on more satisfactorily when he can estimate his income in advance and know that he will be paid for all the service he renders instead of, as at present, for only part of it. He should be as pleased, as we will be, that he gets rid of the job of collecting from the rich to pay for the services furnished to the poor.

The policy of allowing the doctor himself to choose the method by which he shall be paid by the social insurance fund seems to us a sound principle. We have serious doubts as to whether the fee-for-service method is a satisfactory or desirable method of paying general practitioners. But so long as the quality and cost of medical services are adequately safeguarded, we would prefer to let the doctors come to this conclusion themselves, as many of them, of course, have already done.

The Wagner-Murray-Dingell bill also includes a number of provisions designed directly to improve the quality of medical care. These are sound, on grounds of public policy. Along with compulsion by government on the contributions, goes a responsibility to safeguard quality and to stimulate further progress.

There are many parts of our country which lack hospitals and other facilities necessary for modern medical care. Some of these communities would be able to find the capital funds for hospital construction if they knew that, through social insurance, the people living in the community would be able to pay for the use of the hospital once it was built. There are many communities, however, which need help in financing the costs of construction. Workers in war centers and in over expanded cities are acutely aware—from harsh experience—of the dangers of inadequate health facilities. Labor supports the hospital construction program embodied in the Wagner-Murray-Dingell bill, and the priority given in the bill to construction projects in rural and distressed areas. However, the construction of hospitals and health centers in poor areas without simultaneous provisions enabling people to pay for care to be received in these institutions must not leave the country with a series of beautiful but useless buildings. Health insurance alone cannot guarantee adequate medical care to all workers and their families until some additional facilities are available. The Wagner-Murray-Dingell bill takes care of both parts of the problem; it provides through insurance that the facilities can be effectively used and supported. The bill also rounds out a strong national health program, by strengthening the present Federal-State public



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health and maternal and child health and welfare program. Labor has long supported these programs and will continue to do so.

There are two other features of the Wagner-Murray-Dingell bill which I would commend to your attention. One is the inclusion of health insurance as one part of a comprehensive national social insurance system. A unified social insurance system is more economical than a series of separate systems; it is more understandable; and it is necessary if the worker is to have what he wants and needs—not merely benefits for this contingency or that, but social security against all the common risks that threaten his economic independence in modern society.

Second, I would commend the large and important responsibilities which the bill would give, in every phase of administration, to representative advisory bodies. The insistence of the American Federation of Labor on the inclusion of these provisions was based not only on our traditional reliance on democratic methods but drew as well on our considerable experience with policy committees representing the groups concerned gained during the war period.

The medical profession has the assurance, therefore, that, on matters of strictly professional concern, the advisory groups shall consist solely of physicians. On all other matters, the workers covered by the system, employers, persons with special technical competence and representatives of the public would maintain a continuous scrutiny of policy and administration. There would be regional and local as well as national advisory councils. This is the democratic method. Anyone who continues to shout "regimentation" or "dictatorship" must convict himself either of failure to have read or of failure to have understood the bill.

As many of you know, organized labor in this country has not always supported health insurance. We have not drifted into our present position. We have come to it through years of experience and careful study. Back in the 1920's the American Federation of Labor took a position against health insurance. But now after nearly a quarter of a century we see our nation, in spite of its great resources of wealth and scientifically trained personnel, in eighth place among the nations of the world with respect to infant mortality. We see that we are somewhere between eighth and twelfth place with respect to the death rate of children and adolescents and in twenty-first place for persons in middle life. These figures reflect a health picture that American labor is not proud of. The old system has been weighed in the balance and found wanting. The need for more adequate medical care has been amply demonstrated in the studies of the Committee on the Costs of Medical Care, in the National Health

Survey and still more irrefutably in the results of the Selective Service examinations.

The failure of voluntary methods of insuring against the costs of medical care has also been fully demonstrated. Voluntary insurance can never hope to reach the mass of people—the low income groups, and the aged or persons with chronic ailments, all those most in need of protection. Even the proponents of voluntary insurance are beginning to admit that it cannot do the whole job or the main part of the job that needs to be done. The task is one which calls for the participation of all of us through democratic governmental action.

In closing I would like to stress the fact that it is not merely the officials of the American Federation of Labor who support the Wagner-Murray-Dingell bill. It was first introduced at our request made in response to the insistence of our membership that something be done to provide a broad social insurance program including health insurance. Since the introduction of the bill two years ago it has been widely discussed in countless meetings of local unions, city central bodies, in state conventions and conventions of our national and international unions from one end of the country to the other. Even during the stress of war-time its presentation enjoyed continual prominence in the official journals of our national and international unions and in the network of local labor papers. After nearly two years of such thorough airing the delegates to the 64th Annual Convention of the American Federation which met in New Orleans unanimously endorsed the principles of the Wagner-Murray-Dingell bill and instructed their Committee on Social Security to work with President Green in preparing and submitting a new bill. Senate bill 1050 is in large measure the result of those efforts and reflects the purposes of the Convention.

That the leaders of the American Federation of Labor were accurately interpreting the desires of the rank and file in this respect is supported by numerous public opinion polls in which the American people have indicated that they regard the provision of adequate medical care as one of the most important guarantees for the future, and that they are not afraid to work together through their government to achieve a sound national health program.

This is democracy in action. To be sure, it is the opponents who have proclaimed they are the defenders of liberty, freedom and democracy; it is the opponents who have shouted "regimentation," "bureaucracy," and "Socialized medicine." Mark well, however, that all the cries add up only to saying they do not trust democracy and they have no faith in the government of a democracy. They—the opponents—are the defenders of the status quo and even special privilege. Health is as important to democracy as education. Health services are not for the



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privileged few. The workers and the families of America—all of them—need, want and mean to have access to modern health services.

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VETERANS CARE

In accordance with the direction of the Council of the South Carolina Medical Association, a visit was made to Washington, D. C. on April 10th and 11th for conferences with the Veterans Administration relative to an agreement for providing examinations and rendering medical service to veterans by civilian doctors. No stereotyped form of agreement is required and the matter may be handled in several different ways. Various types of agreements have been entered into with the medical associations in certain states, and with a Medical Service Plan or Hospital Service Plan in others.

Primarily, the purpose of the arrangement is to provide a fixed, reasonable, uniform schedule of fees for examinations and all types of medical and surgical treatment of veterans, to be approved by the Veterans Administration. The schedules which have been approved in the states where agreements have already been entered into, appear to be generally fair and equitable. It is clearly the attitude of the Veterans Administration to cooperate with the profession and there was no evidence of a desire to depress the fee schedule. The requirement is that the fees be in keeping with those prevailing in the state for services to regular patients. Examinations for the purpose of determining the nature of the ailment and whether or not it is service-connected, are paid for by the Veterans Administration at all events. Except the examination, however, medical services will be paid for by the Veterans Administration only for conditions which are reasonably determined to have been caused or aggravated by or in the course of military service. In emergency cases, of course, and in others as well, services rendered a veteran before approval of his claim but for a condition which is later established as service-connected, will be paid for by the Veterans Administration—as well as those rendered after approval.

In South Carolina the matter may be handled in one of four ways:

FIRST: The State Medical Society may furnish the Veterans Administration and have approved by it a schedule of fees agreeable to the profession, and along with this a complete list of the physicians in the state who will voluntarily agree to conform to the standard and render services accordingly. The administrative work may be left entirely to the Veterans Administration. Its procedure would be something like this. On receipt of application from a

veteran for medical services, he would be furnished with a list of the doctors in his community who have agreed to participate in the program, and the veteran would then seek the services of the physician of his choice from the list furnished. The doctor would furnish a report to the Veterans Administration and would be paid at regular intervals, probably once a month, for all cases handled by him during the month.

SECOND: The State Medical Association may enter into an agreement or stipulation with the Veterans Administration whereby the procedure outlined in the preceding paragraph would be followed, with the additional responsibility on the part of the Association to appoint and furnish a committee from its membership to act in cases where there is any dispute or controversy as to the quality of the services rendered, or the compliance by the physician with the requirements of the Veterans Administration as to the reports or charges by a physician. All applications for medical service and reports by the physicians would be cleared through the office of the Medical Association and by the latter to the Veterans Administration Office in Columbia. On approval by the latter, of the veteran's claim, the doctor would be so notified and funds would be transmitted by the Veterans Administration to the Association office and by the latter paid out and distributed to the doctors entitled to receive the same, at monthly intervals for services rendered during the preceding month. This is generally the plan worked out by the Kansas State Medical Society, but at the time of the conference with Dr. Harding, this had been in operation only a week and it was impossible to determine how satisfactory the plan might prove to be.

In Kansas, the Veterans Administration agreed to establish a representative in an office adjacent to the office of the medical association to facilitate clearance of the claims and accounts. It was emphasized that in view of the shortage of doctors generally and the great need of men qualified for this work for other important duties within the Veterans Administration, future similar arrangements would be avoided if possible. In South Carolina it would be possible to clear the reports by mail with the Veterans Administration office in Columbia, the chief difficulty apparently being the time-lag due to communication by mail, but this would be of minor importance.

THIRD: The Association might enter a definite agreement with the Veterans Administration to supply all of the necessary clerical help to process the claims and pay, once a month, the bills of the physicians according to the fee schedule determined and approved as outlined above, rendering statement in turn to the Veterans Administration, which would at regular intervals repay the amount paid out by the Association to the physicians rendering services to the veterans. This plan is in process of develop-

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ment in Pennsylvania and New Jersey, with 7% of the amount handled through the office of the Association being allowed to it by the Veterans Administration, in addition to the actual total amount of the fees, to pay the cost of the additional clerical help, supplies and incidental expense required.

FOURTH: An arrangement similar to that outlined in the preceding paragraph (Third) could be worked out with the state Blue Cross Plan, when organized, or possibly, with the Greenville County Hospital Benefit Association now being operated in several counties in that area. This is the system employed in Michigan, with Michigan Medical Service, in California with California Physicians' Service, and with the Hospital Saving Association of North Carolina, a Blue Cross Plan.

Representatives of the Greenville County Medical

Society conferred with Dr. Harding of the Veterans Administration on the day following our conference, and according to our information, obtained approval of a schedule of fees for use in Greenville County, which we understand, they propose to operate through the Greenville County Hospital Benefit Association. It is, of course, uncertain at this time, what plans the state association will adopt, and the purpose of the above is to acquaint the members of the association with the various alternatives offered. (At the recent meeting of the House of Delegates, recently held at Myrtle Beach, the Association voted to adopt the plan presented by the Greenville County Medical Society which will operate through the Greenville Hospital Benefit Association.—Editor)

NEWS ITEMS

The Laurens County Medical Society held its April meeting at the Laurens County Hospital April 22. A chicken dinner, served in the hospital dining room, was followed by the scientific program, which was in charge of Dr. Vincent.

The meeting was presided over by Dr. Dusenberry. Following routine business matters, two interesting talks were heard by guest speakers from Columbia.

Dr. William Cantey spoke on "The Practical Aspects of Cancer of the Colon and Rectum."

Dr. Heyward Gibbes spoke on "The similarity of the symptoms of Hookworm Infection and Duodenal Ulcer."

Both these papers were discussed by the members present.

Dr. Richard Ferguson was present as a guest. Members present were: Doctors Shealy, Blalock, Rhame, Teague, Vincent, Dusenberry, McFadden, Davis, Nickles.

CHESTER COUNTY MEDICAL SOCIETY MEETS

The Chester County Medical Society held its monthly meeting at the Chester Hotel on Tuesday, April 2nd at 7:30 P.M. Dr. W. T. MacLauchlin of Great Falls, Vice-President, presided in the absence of Dr. A. M. Wylie, President. After a Dutch Supper at the Chester Hotel, the doctors adjourned to Dr. J. N. Gaston's office for the program. Those present included: Dr. Henry, Dr. Hennies, Dr. Hicks, Dr. Patterson, Dr. Wallace, Dr. Gaston Jr., and Dr. MacLauchlin. Among the guests were: Dr. Isaac

Phifer of Spartanburg, Dr. Clarence Cross Lyles of Chester, and Malcom Marion of Chester, a senior at the S. C. Medical College of Charleston.

Dr. Wallace read a letter from Dr. Keith Smith of Greenville requesting material for a Medical Exhibit at the S. C. Medical Association Meeting at Myrtle Beach on April 30th, May 1st and 2nd. Dr. Wallace told of having letters in his possession in the hand writing of Dr. Crawford W. Long of Georgia who was the first Doctor to use an "Anesthetic" in the U. S.

Dr. Patterson told of getting a case of dried blood plasma from the State Board of Health as did the Health Department. This plasma will be distributed to all county doctors free of charge.

Dr. Hicks told of the new Tuberculosis Fluoroscopic Clinic to be held at the County Health Department on April 15th at 10:00 A.M. and every third Monday thereafter. Dr. Moncrief of State Park will send one of his assistants to hold these clinics.

Dr. Wallace introduced Dr. Phifer of Spartanburg who is to hold a Urological Clinic at the Pryor Hospital every other week beginning Tuesday, April 16th.

Dr. Wallace introduced our guest speaker, Dr. James McLeod of Florence who is President-elect of the S. C. Medical Association and is to take office as President in May. Dr. McLeod made a forceful talk on the "Future of Medicine in the United States." He pointed out that the new Wagner-Murray-Dingell bill now before Congress is not only a bill to socialize medicine and regiment all doctors, but is an entering wedge that will split our American way of life wide open and result in confusion and communism as great as that seen today in Russia. He strongly advised all doctors and interested citizens to write our Congressmen and representatives in Washington to fight this bill.

SOUTHERN PEDIATRIC SEMINAR

26TH SESSION

MEETS JULY 15 - JULY 27, 1946,

SALUDA, NORTH CAROLINA

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Oren Moore, M.D., Dean of Obstetrics

Frank Howard Richardson, M.D., Vice Dean

D. Lesesne Smith, Sr., M.D., Registrar

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Francis B. Johnson, M.D.,
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J. Warren White, M.D.,
Greenville, S. C.

William Weston, Jr., M.D.,
Columbia, S. C.

Hamilton McKay, M.D.,
Charlotte, N. C.

William Weston, Sr., M.D.,
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Angus M. McBryde, B.S. M.D.
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Warren W. Quillian, M.D., F.A.A.P.
Miami, Florida

R. M. Pollitzer, M.D.
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Julian P. Price, M.D.,
Florence, South Carolina

Robert Lawson, M.D.
Winston-Salem, N. C.

Lee Bivings, M.D.,
Atlanta, Georgia

Hughes Kennedy, M.D.,
Birmingham, Alabama

George R. Wilkinson, M.D.
Greenville, S. C.

Amos Christie, M.D.
Nashville, Tennessee

Keitt Hane Smith, M.D.,
Greenville, S. C.

George Dean Johnson, M.D.,
Spartanburg, S. C.

Doctor Richard Torpin, Professor of Obstetrics and Gynecology of the University of Georgia Medical School, was guest speaker at the monthly meeting of the Spartanburg County Medical Society. Forty members were present to hear Dr. Torpin's paper on "The Physiology of Labor" which was most interesting.

Drs. James D. Nelson, M. A. Allen, W. Clough Wallace and James Jeanes were accepted as new members in the Society.

The Laurens County Medical Society held its March meeting at the Hotel Clinton. Dr. Martin Teague of Laurens talked most interestingly on the use and administration of penicillin.

Dr. D. H. McFadden of Goldville was welcomed as a new member of the Society.

Officers for 1946 are: Dr. James Dusenberry, President; Dr. C. R. Blalock, Vice President; Dr. D. O. Rhame, Secretary-Treasurer. Dr. Teague was named as delegate to the annual meeting of the S. C. Medical Association.

HONOR DR. JORDAN AT SURPRISE PARTY

(Greenville News, April 16)

Some 2,000 friends, a large number of whom were "Dr. Jordan's babies," gathered at Verner Springs park for a surprise party held in honor of Dr. Fletcher Jordan and to present him with a 1946 attended the surprise affair to express their appreciation of his contribution to mankind during his 38 years as a practicing physician in Greenville.

The group, ranging from babes in arms to a grandmother all of whom Dr. Jordan delivered at birth, in addition to his host of friends throughout the city, attended the surprise affair to express their appreciation for his understanding and unflinching work during approximately four decades.

About 400 of the approximately 3,500 babies delivered by Dr. Jordan participated in the "Jordan Baby Parade" held at the outset of the party.

From the time of his arrival shortly before 6 p.m., Dr. Jordan was surrounded by well-wishers who kept him so busy shaking hands and renewing acquaintances that he never was able to eat the picnic lunch served on the grounds.

Peace Presides

Roger C. Peace presided over the session. Included on the program, in addition to the baby parade and picnic lunch, were short talks by Mr. Peace, C. Granville Wyche, music by the Parker high school band, a song written especially for the occasion and sung by the entire group, and a violin solo by Miss Grace Harrison. L. P. Hollis, superintendent of the Parker schools, led the group in singing the special song.

Mr. Peace presented Mr. Wyche, who declared that an occasion "such as this springs solely from love and friendship." He pointed out that the exercises were being held in honor of Dr. Jordan, but added that "we have with us tonight his partner, without whom Dr. Jordan's career would not have been so successful."

In presenting Dr. Jordan's "partner," Mrs. Fletcher Jordan, Mr. Wyche pointed out that the work of a doctor's wife doesn't carry with it the satisfaction of caring for a baby.

Silver Set Presented

"It's a good thing Mrs. Jordan is not a jealous woman," he said, "because many women in Greenville are in love with Dr. Jordan." Mr. Wyche pre-

sented the silver set, which included a tray, pitcher and 12 goblets, to Dr. Jordan "in token for his service to mankind," as the inscription on the tray read.

Mr. Peace, speaking at the conclusion of Mr. Wyche's brief talk, pointed out that "we love him (Dr. Jordan) as a physician and a man. He is a man who has deserved success," Mr. Peace added, noting the long years of faithful service rendered by the 67-year-old physician.

Mr. Peace then asked Dr. Jordan to follow a rope which was tied to his chair and strung to a point on the opposite side of the building where the new 1946 Chrysler stood. Surrounded by his many admirers Dr. Jordan walked to the car, was helped into it by Dr. John Fewell, and shortly was driven to his home.

So happy, yet bewildered, was the physician that he was hardly able to speak. The same smile which greeted each of his patients throughout his many years of service was predominant throughout the night.

Dr. Jordan's immense popularity was shown by the many friends who stopped to shake hands and speak with him briefly. There were few persons he did not remember by name, many of whom have called Dr. Jordan for medical assistance for some 30 years.

Various-Size Families

A number of parents were accompanied by three and four children, all of whom Dr. Jordan delivered, and it was frequent that teen-age girls seized the opportunity to kiss him on the cheek as a token of their appreciation. Some of the young men attending the party were still in military uniform, and a still larger number wore the official discharge emblem denoting their service with the armed forces. There were several couples, both of whom were delivered by Dr. Jordan at birth and who now are married.

The party was made possible by contributions from the numerous friends of Dr. Jordan. A committee, members of which desired to remain anonymous, made final arrangements and arranged for the purchase of the car and silver service.

The committee found it necessary to solicit the cooperation of local automobile dealers in purchasing the car. It was understood that Dr. Jordan had been attempting to purchase a new car for some time, but through the cooperation of local dealers, the committee arranged to postpone his purchase and for him to be given the Chrysler presented last night.

While the affair was known as "Fletcher Jordan Day," the number of persons attending the party who were delivered at birth by Dr. Jordan gave added emphasis to his untiring work throughout the years.

In fact, this writer is one of "Dr. Jordan's babies."

CLUB AT GAFFNEY, S. C., TO HONOR DR. NESBITT

Gaffney, S. C., March 19—The Crustbreakers club will honor Dr. D. N. Nesbitt, Gaffney's oldest practicing physician, in a testimonial dinner which will be open to the public here April 15, it has been announced by officials of the club of which Dr. Nesbitt is a member.

Dr. Nesbitt, 80 years old next July, has practiced here 58 years. He practiced at Taylors for eight years before coming to Gaffney in January, 1898. He is a native of Spartanburg county where he was born July 12, 1866. He studied medicine and graduated from the University of Tennessee at Knoxville.

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The Crustbreakers have named this committee in charge of arrangements for the dinner: Dr. R. C. Cranberry, chairman, and Dr. S. B. Sherard, J. C. Fort, A. W. Askins and Dr. R. A. MacFarland. The latter was placed in charge of ticket sales.

Dr. Nesbitt's service covers the development of Cherokee county and Gaffney for more than half a century. There were no telephones and automobiles and no improved roads when he came here. He

answered calls on horseback and later in a buggy until the automobile became available.

He married Miss Juliet Lancaster Lipscomb, daughter of the late Mr. and Mrs. Nathan Lipscomb, April 26, 1899. He had three children by a previous marriage, James, Mary and Eula and three others were born to his second union, Juliet who died when she was 14 years old and Kate and Sara Nesbitt.

PUBLIC HEALTH NEWS

LEGISLATURE APPROVES \$12,425,000 BUILDING AND EXPANSION PROGRAM FOR PUBLIC HEALTH

State to Provide 40 Per Cent of Cost, Federal Government 60 Per Cent

The General Assembly has made provision for the expenditure of approximately \$5,000,000 as the State's share of a proposed \$12,425,000 building and expansion program for public health in South Carolina. The program hinges on federal legislation expected to provide 60 per cent of the total cost.

In addition to the building of hospitals and health centers, the bill authorizes improvements for practically all State-supported institutions and allots \$1,770,000 in State funds to be used by the counties as they see fit. Allocations to counties will be based on a plan whereby no county will receive less than \$30,000.

Each of the 46 counties will get \$20,000, plus \$5,000 for each Representative in the General Assembly, for use in matching federal grants for erection of health centers, purchase of equipment and supplies for hospitals, for payments on outstanding bonds for health centers, or for hospitalization of indigent citizens.

The largest single item in the bill is \$1,500,000 for the Medical College of South Carolina. This amount will be more than matched by federal funds. Other items include \$300,000 for the South Carolina Sanatorium, which proposes to build a 200-bed hospital for Negro patients, construct housing for employees, particularly nurses and physicians, add to kitchen facilities, and improve water and sewage disposal systems; and \$200,000 for a venereal disease hospital to be built near the City limits of Columbia on land now used by the South Carolina State Hospital. Authority has been granted by the Legislature for conveyance to the State Board of Health of necessary land upon which to construct the venereal disease hospital. The land proposed for conveyance is situated on an extension of Confederate Avenue and adjoins the property of the Association of the Blind.

Also included in the bill are \$300,000 for the State Training School at Clinton; \$200,000 for Clemson College Infirmary; 50,000 for the State A. and M. (Negro) College; \$50,000 for the S. C. School for the Deaf and Blind; \$150,000 for a girls' infirmary at the University of South Carolina; and \$75,000 for the Citadel Infirmary.

The only condition to expenditure of the money is a stipulation that counties provide lands necessary for all building improvements.

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**SOUTH CAROLINA PUBLIC HEALTH ASSO-
CIATION MEETS AT MYRTLE BEACH
MAY 27, 28 AND 29**

**Interesting Program Planned—Large
Attendance Expected**

The S.C.P.H. Association will hold its 23rd annual meeting at Myrtle Beach Monday, Tuesday, and Wednesday, May 27, 28 and 29. It will be the first held at Myrtle Beach since 1941 and will probably be one of the largest and finest since the Association was organized.

Dr. H. Grady Callison, Chairman of the Program Committee, has announced that an exceptionally interesting program is being arranged and that several outstanding leaders in public health have accepted invitations to speak. The meetings will be held as usual in the Gloria Theater and will adjourn each day at one o'clock.

Mimeographed programs and lists of available accommodations at Myrtle Beach, with rates and number of persons each place can take care of, will be mailed to each County Health Department as soon as completed. Each person will make his own hotel arrangements.

Officers of the Association are: Dr. M. J. Boggs President; Dr. Hilla Sheriff, President-Elect; H. D. McDaniel, 1st Vice-President; Mrs. Sudie Bolin, 2nd Vice-President; and Mrs. Frank George, R. N., Secretary-Treasurer. Dr. Ben F. Wyman represents the SCPHA on the Governing Board of the American Public Health Association.

**BIRTHS AND DEATHS TO BE REPORTED
THROUGH COUNTY HEALTH DEPARTMENT
UNDER NEW LAW**

Under a recent Act passed by the General Assembly, local registrars will be required to transmit all records of births and deaths to the State Board of Health through intermediary registrars which will be established in the County Health Departments.

Original laws for the collection of birth and death records were passed approximately thirty years ago and provided for local registrars and the State registrar, and authorized local registrars to transmit reports on births and deaths directly to the Central Office in Columbia.

The new method of handling birth and death records will be instituted as soon as possible and not later than July 1, 1946. Full details will be provided all County Health Departments.

The new Act does not interfere in any way with the status of local registrars or the Clerks of Court, but is specific in the establishment of intermediary registrars.

**NEARLY 3,000 PACKAGES OF BLOOD
PLASMA DISTRIBUTED BY STATE BOARD
OF HEALTH EXPECTED TO SAVE
MANY LIVES**

The State Board of Health has completed the distribution of 2,686 packages of blood plasma to the 46 county health departments and 62 hospitals. This dried blood plasma was surplus to the needs of the War and Navy Departments and is being redistributed without cost by the American Red Cross to the people of this country who so generously gave it for the war effort. It is being distributed through the various state boards of health and it is the desire of the American Red Cross that all hospitals and practicing physicians have the use of it.

Each county health department received one package of plasma for each licensed physician in the county, according to the latest published list of the State Medical Association. The health departments will distribute the plasma to these physicians upon request. The hospitals received an allotment of one package of the plasma for each three beds as listed in the Journal of the American Medical Association. County health departments and hospitals will furnish the State Board of Health monthly reports on the amount of plasma used during the month and on hand on the first of each month. Replacements of plasma will be made on the basis of use as far as the allotment to the State Board of Health will allow. Surplus dried blood plasma is limited, and the amount received by the various agencies is estimated to be about what would be needed in a three months' period. The State Board of Health expects to request additional allotments on the basis of the monthly reports received and in this way keep the hospitals and health departments resupplied as rapidly as the plasma can be secured. This allotment of dried blood plasma will meet a great need in making this product available to many patients who could not otherwise secure it. It can be expected to save many lives in South Carolina.

Dried blood plasma is indicated and very useful in such cases as: shock, due to hemorrhage, burns, and abdominal injuries; hypoproteinemia; immune therapy; deficiency of complement, deficiency of prothrombin and hemophilia. In some of these diseases whole blood is preferred if it is available.

Dried blood plasma is not without some danger. Adverse reactions sometimes occur from the administration of dried blood plasma and may be due to heating the plasma prior to administration, bacterial or virus contamination or other reasons. The processing of the plasma does not as a rule inactivate a virus and it is possible that some lots may contain an active virus. Serum jaundice has been reported to be transmitted by blood and plasma transfusions. This serum jaundice may occur one to four months after the administration of contaminated plasma. Physicians should use plasma only where definitely indicated.

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SOUTH CAROLINIANA

J. I. WARING, M.D., CHARLESTON, S. C.

BELL, J. E., and J. A. BOONE (Charleston): Neostigmine methylsulfate an apparent specific for arachnidism (black widow spider bite). (J.A.M.A. 129:1016-1017, Dec. 8, 1945)

The authors noted that dramatic relief was secured within an hour by intramuscular injection of 2 c.c. of 1:2000 neostigmine methylsulfate combined with atropine. One case is reported.

BOONE, J. A. (Charleston): Ventricular fibrillation as a complication of hyperthyroidism. (Am. Heart J. 29:751-754, June, 1945)

A case report of an unusual occurrence in hyperthyroidism, in which auricular disturbances are more common. This is thought to be the first proven case of its kind. The patient recovered.

BOONE, J. A., COLEMAN, R. R., and PRYSTOWSKY, S. (Charleston): Peptic ulcer as a cause of abdominal symptoms in congestive heart failure. (South. Med. J. 38:753-755, Nov., 1945)

Symptoms usually ascribed to chronic passive congestion may be due to peptic ulcer. The authors found that ulcer was very common in a group of patients with heart failure, and that the usual ulcer management gave relief to the abdominal complaints.

BOONE, J. A.: See Bell, J. E., jt. author.

BUEKER, E. D. (Charleston): Hyperplastic changes in the nervous system of a frog (*Rana*) as associated with multiple functional limbs. (Anat. rec. 93:323-331, Dec., 1945)

Studies on a frog with a spare leg.

Ibid.: The influence of a growing limb on the differentiation of somatic motor neurons in transplanted avian spinal cord segments. (J. Comp. Neurol. 82:335-361, June, 1945)

A study of growth.

Ibid.: The influence of the periphery on the differentiation of the embryonic chick spinal cord. (American Philosophical Society. Yearbook, pp. 42-46, 1945)

Limb primordia were removed from 2½ day chick embryos. Volumetric studies and cell counts show that the lumbosacral spinal cord is not a self differentiating structure. In the absence of a growing limb hypoplasia occur in the white and gray matter. These changes begin to show at 4 days total incubation and reach a maximum after the nerve tracts are myelinated.

COLEMAN, R. R.: See Boone, J. A., jt. author.

ELLIOTT, H. C. (Charleston): Cross sectional diameters and areas of the human spinal cord. (Anat.

rec. 93:287-293, Nov., 1945)

As titled.

HANCKEL, R. W., Jr. (Charleston): Some observations concerning the Salzer method of treatment of lye burns of the esophagus. (South. Med. J. 39:263-264, March, 1946)

Early dilatation with bougies gives best results. Details of procedure and results of treatment are given.

HARD, W. L. (Charleston): A histochemical and quantitative study of phosphatase in the placenta and fetal membranes of the guinea pig. (Am. J. Anat. 78:47-78, Jan., 1946)

As titled—no clinical application is suggested.

JERVEY, J. W., Jr. (Greenville): Views and reviews. (South. Med. J. 39:4-8, Jan., 1946)

A discussion of many points, including socialized medicine, the Negro, and the need for a clear head and a warm heart in considering the problems of the profession.

KREDEL, F. E. (Charleston): Headaches from lesion of scalp nerves. (Ann. surg. 122:1056-1059, Dec., 1945)

Local surgical treatment is likely to give benefit in these cases. Injection gives variable results.

LASSEK, A. M. (Charleston): The human pyramidal tract. XII. The effect of hemispherectomies on the fiber components of the pyramids, by A. M. Lassek and J. P. Evans. (J. Comp. Neurol. 83:113-119, Aug., 1945)

A study of material from human subjects who had had cerebral operations.

Ibid.: The human pyramidal tract. XIII. A study of the pyramids in cases of acute and chronic vascular lesions of the brain. (Arch. Neurol. & Psychiat. 54:339-343, Nov.-Dec., 1945)

In these conditions there may be little or no destruction of the pyramidal tract, although they are more destructive than are cerebral tumors.

Ibid.: The role of the northeastern medical schools (exception New York) in the national distribution of physicians. (J. Assn. Am. Med. Colleges 20:290-295, Sept., 1945)

Statistical studies of a group of medical schools.

Ibid.: The pyramidal tract. The representation of the lateral corticospinal component in the spinal cord of the cat. (J. Neuropath. & Exp. Neurol. 5:72-76, Jan., 1946)

In the common experimental animal, the cat, the pyramidal tract was found to occupy an intermediate

position between lower mammals and man. It extends mainly to the upper two-thirds of the spinal cord and is largely a mixed tract in this region.

----- and Wheatley, M. D. The pyramidal tract. An enumeration of the large motor cells of area 4 and the axons in the pyramids of the chimpanzee. (J. Comp. Neurol. 82:299-302, June, 1945)

A continuation of microscopic studies.

LAUB, G. R. (Columbia): Rhinitis vasomotoria due to imbalance of the endocrine glands. (Laryngoscope 55:179, April, 1945)

Dr. Laub discusses one of the rather infrequently recognized causes of vasomotor rhinitis. The difficulty of accurate diagnosis of endocrine disturbances makes specific treatment rather hard, but cases are cited in which relatively simple measures seemed to be very effective.

MACE, L. M.: See Smith, H. G., jt. author.

MOOD, G. McF.: Young, R. M., jt. author.

PARKER, E. F. (Charleston): Early pulmonary decortication in the treatment of post-traumatic empyema, by Major Thomas H. Buford, Major Edward F. Parker, and Major Paul C. Samson. (Ann. surg. 122:163-190, Aug., 1945)

Review of 25 cases, 19 of which obtained primary cure. Penicillin was used to safeguard the surgery. Cases are cited and the subject is discussed in detail.

PRATT-THOMAS, H. R.: See Smithy, H. G., jt. author.

-----: See Waring, J. I., jt. author.

PRESSLY, W. L. (Due West): The general practitioner: opportunity and responsibility. (South. Med. J. 38:552-554, August, 1945)

A sincere eulogium of the life of the general practitioner.

PRIOLEAU, W. H. (Charleston): Full-thickness flap closure of large thoracotomy due to chemical destruction of chest wall. (J. Thoracic Surg. 14:433-437, Dec., 1945)

Operation by para-vertebral thorocoplasty and sliding full-thickness flap of chest wall successfully repaired damage due to injection of nitric acid.

PRYSTOWSKY, S.: See Boone, J. A., jt. author.

RAY, T. (Charleston): The intravenous administration of Lanatoside C to patients taking maintenance doses of folia digitalis up to the date of hospitalization with recurrent congestive heart failure, by Thiesen Ray and John S. LaDue. (Am. Heart J. 30:335-340, Oct., 1945)

The authors find this drug satisfactory and effective in congestive heart failure in digitalized patients.

RUDISILL, H., Jr. (Charleston): Effect of radia-

tion on malaria. An experimental study in the chick and duck, by R. H. Rigdon and Hillyer Rudisill, Jr. (Proc. Soc. for Exp. Biol. & Med. 59:167-170, June, 1945)

The live chick is very nearly dead if he is given enough irradiation to affect his parasites materially. Radium bromide was ineffective.

SMITHY, H. G., PRATT-THOMAS, H. R., and MACE, L. M. (Charleston): Reestablishment of pancreatic secretion into the intestine after division of the pancreas: an experimental study. (Arch. of Surg. 51:164-171, Oct., 1945)

A technique of implanting the transected uncinate process of the pancreas into the jejunal wall has been developed for dogs, and may have applications for the human.

WALLACE, F. T. (Charleston): Technical details in dermatome grafting. (South. Med. J. 38:380-381, June, 1945)

Valuable details gained from experience with the Padgett dermatome.

WARING, J. I. (Charleston): Sedation as an unexpected systemic effect of privine. (J.A.M.A. 129:129-130, Sept. 8, 1945)

Privine is similar in effect to ephedrine in that large doses may produce sedation, whereas both drugs are ordinarily stimulant.

----- and PRATT-THOMAS, H. R. (Charleston): Congenital dermal sinus as a source of meningitis. (J. Pediat. 27:79-83, July, 1945)

Case report of 3 bouts of meningitis in a child with this congenital defect.

WHEATLEY, M. D.: See Lassek, A. M., jt. author.

WHITE, J. W. (Greenville): Colles' fractures. (South. Med. J. 38:415-417, June, 1945)

X-ray, anaesthesia, anatomical reduction are essential. Plaster is better than splinting. Finger motion is wise, and physical therapy should be mild.

WILSON, L. A., Jr. (Charleston): The incidence of malignant tumors in British West Indian and Panamanian Negro autopsy populations, by W. J. Tomlinson and L. A. Wilson, Jr. (Cancer research 5:368-371, June, 1945)

A statistical study.

YOUNG, R. M. and MOOD, G. McF. (Charleston): Effect of penicillin on infection of guinea pigs with *Corynebacterium diphtheriae*. (J. Bact. 50:205-212, Aug., 1945)

Experiments *in vitro* show that penicillin is very effective against the organism of diphtheria, and is also effective in prophylaxis and therapy in guinea pigs.

CORRESPONDENCE

Dr. Julian P. Price, Editor
Journal of the South Carolina Medical Assn.
Florence, S. C.

Dear Julian:

As you know, the Medical History Club of Charleston is now twenty years old, having been founded in November, 1925. Although I was not there myself, having been much too young at that time, I have it on good authority that this is the way it came into being:

**An Inquiry into the Causes of the Revival of
Interest in Medical History in Charleston in
the Nineteen-twenties. With Especial
Reference to the Founding of the
Medical History Club.**

A bunch of the boys were whooping it up in the Medical Faculty room,
At least, they were trying their best to whoop but they couldn't quite get the tune;
They had just come in from the Roper and the blood still dripped from their boots;
You could tell from the looks on their faces these lads were in cahoots.

The old Commodore was spinning a yarn with his arms flung high and wide,
And Doctor Phillips was listening—he recked of formaldehyde;
When young Billy Smith—he was quite young then—burst into the room with a shout:
“There’s something that’s been on my mind for a year, you boys must help me out!”

“Day after day, when I’ve finished my work and I want to go out and get tight,
My wife locks the doors and hides all the keys, and I’m stuck at home for the night.”
The old Dean laughed; “That’s nothing,” he said,
“You’ll never be able to stray;
If it were not for the Medical School I wouldn’t get out in the day.”

Deep silence fell upon the group and their heads hung down in shame,
As each in turn admitted that his plight was just the same;
And all were in solemn agreement that until they held the keys
They didn’t have even the slimmest chance to go out and eat some cheese.

But there was one great exception: the Anatomic Pedagogue
Stood up with all the dignity of the Diabetic Dog,
And in a pompous pose announced: “It would not be amiss
To say again what I have said, That singleness is bliss.”

That sort of got their dander up, and with hopeful speculation
They wondered what old Galen did in such a situation,
Or what Hippocrates would do to give his wife the slip
And mingle with the other Greeks to take a little nip.

Then suddenly somebody opened the door, and seated in the hall
They spied the man who was to be the noblest Roman of them all;
Smith, the colored janitor, completely at his ease,
Partaking of his midnight snack of beer and crackers and cheese.

“That’s it,” they cried, “We’ve got it now, although it’s getting late,
It won’t be long before we’re out from the back of ball number eight;
If proper amounts of History are mixed with crackers and cheese,
The answer is, as everyone knows, a set of duplicate keys.”

Then George McFarland Mood chimed in: “Although I am no toper,
I’d like the chance to talk about the History of the Roper.”

“That’s a capital thought,” the Dean remarked, “We’ll shoot some historical breeze,
Then we’ll all settle down with a drink of good Scotch, and dig into the crackers and cheese.”

Old Ned was partial to oyster stew, and Leon to spaghetti and ham,
And the way Joe and Frank would feed the boys was tough on the diaphragm.
But when the lads are gathered around and are really at their ease,
They’ll take a dram or two of Scotch and nibble on crackers and cheese.

Sincerely yours,

(Bob)

Robert Wilson, Jr., M.D.

BOOK REVIEWS

GOVERNMENT IN PUBLIC HEALTH

By Harry S. Mustard, New York, The Commonwealth Fund—1945

This is an excellent book by an eminent South Carolinian which can be read with profit by all physicians, especially since the topic is one which will demand an increasing amount of careful attention from all of us. Rather than attempt a detailed review, we offer here a brief abstract of the subject matter, although a perusal of this refreshing mixture of sound and sufficiently unbiased analysis, humor, and good English will be a very worth while endeavor.

Dr. Mustard starts by giving full credit to the private physician for his part in the development of the knowledge and practice of public health measures—He praises the accomplishments of some of the voluntary health agencies, such as the National Tuberculosis Association, but notes the undesirable over-enthusiasm of some organizations which limit their interest to narrow fields, and sometimes, in their “ever upward straining,” forget the place of the physician in the health picture—He points out the difficulty of placing proper emphasis on some of the scientific and practical phases of a public health program when public emotional and enthusiastic trends may transfer weight to less effective efforts.

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- Because of its high purity Penicillin-C.S.C. Crystalline Sodium Salt may be given in high dosage (200,000 units) by aerosol administration.

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100,000, 200,000, or 500,000 units*



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The author discusses the need for coordination and unification of the innumerable federal agencies concerned with public health, and points particularly to the Children's Bureau, which was inaugurated by the feminist element on an emotional appeal, and while deserving credit for much good work, has never been integrated with other official activities.

In an historical review, Dr. Mustard recalls that Mr. Pinckney of South Carolina was the early proponent of a tax on seamen for their own health service—The first "State health officer" was appointed at Charleston in 1712, and a pesthouse existed on Sullivans Island as early as 1698—In later years the tax on seamen was abolished, general tax funds were used, and benefits were extended to a great number of people who had no touch of the sea, salt or fresh—e.g. the C.C.C., W.P.A., etc., etc. Gradually the federal public health service absorbed local services, usually to the advantage of the latter—Proper credit must be given to the Public Health Service for its development of worthy programs.

The Act for Maternal and Child Health set a precedent in federal care for certain separate groups as against the whole population—The requirement that the States must meet certain federal provisions in order to get funds opens up a number of possibilities in the field of federal governmental control of state programs—The war time provision of the program for EMIC covers another segregated segment of the population. Its effects are still sub judice.

Dr. Mustard sees no early prospect of the establishment of a Cabinet member for public health. He goes on to discuss the development of trends for the future expansion of public health activities—He states that activities of local health departments developed from emergency expediences to planned public health required by law—He believes that few local jurisdictions can actually support a proper program, and that federal aid is necessary—Adequate local health service should be mandatory, and poorer units should combine for efficiency, but if local support is to be abandoned, federal service must be adequate, continuing, coordinated, balanced, and effective.

Free inoculation campaigns must be on a mass scale to be effective, and bring work to the private physician rather than take it away.

Dr. Mustard thinks that local health services are still inadequate in many areas, but that they can be provided if the state will submit an inclusive plan for basis services in all areas and secure federal aid. State legislation should require every community to have health service, and if necessary, require coordination of areas where circumstances indicate effective combination. Federal grants-in-aid are usually sound, unless a state fails to do its part in appropriating funds, and becomes parasitic upon the nation. Great credit is due to state health officers, but federal integration is often needed and joint projects can be very effective.

J. I. W.

Bockus, H. L., ed. Gastro-enterology. (in three volumes) Volume III—Diagnosis and treatment of disorders of the liver, gallbladder, biliary tract and pancreas. Intestinal parasites and secondary gastrointestinal disorders. Phila. and London, W. B. Saunders co., 1946.

Undoubtedly Doctor Bockus and members of the faculty of the University of Pennsylvania Graduate School of Medicine have finished a conscientious job with the appearance of the 3rd ponderous and final

volume of Gastro-Enterology—and the General Index to the third volume series. It can be recommended as an expansive compend, excellent for reviewing one's knowledge, with very few of the chapters enriching the special subject matter.

DEATHS

Lucius Cuthbert Brooker

Dr. L. C. Brooker, well known Swansea physician, died at the Baptist Hospital in Columbia on the morning of April 2, after several years of declining health. A graduate of the University of Georgia School of Medicine (1907), Dr. Brooker had practiced his profession in Swansea since his graduation. Surviving are his widow, the former Miss Margaret Brown of Kingstree, and two sons.

David S. Keisler

Dr. David S. Keisler, 68, died at his home in Leesville, March 24. Dr. Keisler was a graduate of the Medical College of the State of South Carolina in the class of 1911. He practiced at Ward from 1911 to 1920 and then moved to Leesville where he practiced until his death. Surviving are his widow, the former Frances Hutto, four daughters and three sons.

Benton McQueen Montgomery

Dr. B. M. Montgomery, 58, died at his home in Kingstree April 2 after an illness. A graduate of the Medical College of the State of South Carolina, Dr. Montgomery had been associated with the South Carolina State Health Department for a number of years. He is survived by his widow, Mrs. Mana Claffy Montgomery; two sons, Lt. B. M. Montgomery, Jr., medical officer with the armed forces in Europe, and Dr. Claffy Montgomery, intern at Roper Hospital in Charleston.

Edgar Rasor Donnalld

Dr. E. R. Donnalld, of Honea Path, died April 6 at his home. Dr. Donnalld had been in declining health since 1937. He would have been seventy years of age on April 26. Dr. Donnalld graduated from Vanderbilt University School of Medicine in 1910 and practiced his profession until 1937 when ill health forced him to retire. He is survived by his widow, one sister and two brothers.

Grover Cleveland Bolin

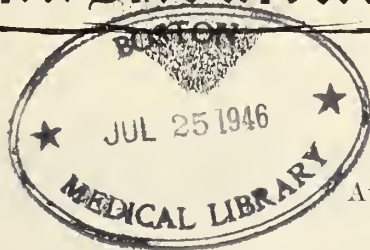
Dr. G. R. Bolin, Health officer for Orangeburg County, died on March 15, 1946.

A graduate of the University of Maryland Medical School (1908), Dr. Bolin practiced medicine in various parts of the state before accepting the position of County Health Officer in Orangeburg in 1922. He is survived by his widow, Mrs. Louella Sheppard Bolin, and two sons, Dr. Paul Bolin of Orangeburg and Wilmington, and G. C. Bolin, Jr. of the Medical College of the State of South Carolina.

The Journal of the South Carolina Medical Association

JUNE, 1946

VOL. XLII, NO. 6



Article

Author

Page

Address

James McLeod, M.D.

147

The Rheumatic Fever Program in
South Carolina

Submitted by Staff of the
Rheumatic Fever Program

150

Annual Meeting House of Delegates

157

Editorials — News Items — Deaths — Woman's Auxiliary

BACKGROUND

Three Decades of Clinical Experience

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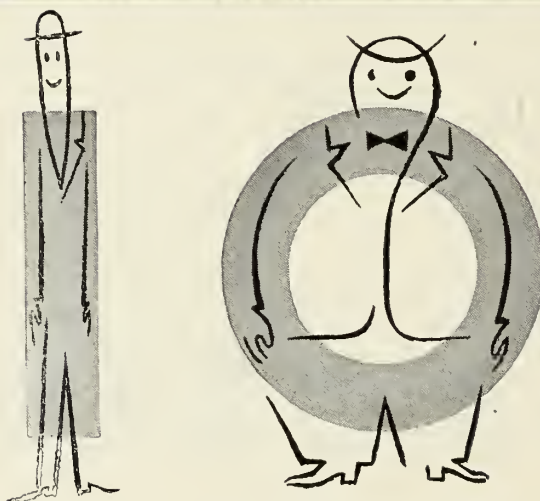
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¹ Handbook of Nutrition, Chicago
A. M. A., 1943, p. 557.



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OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

June, 1946

NUMBER 6

Address*

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Florence, S. C.

Ninety-eight years ago the South Carolina Medical Association was organized. It has come through the years intact. In this day and time when constitutions are so freely discussed, I think we would do well at the beginning of a new year to look at our constitution. I am going to take the liberty at this time of reading to you the opening paragraph of our Constitution as drawn. As you will see, the men who wrote this had great vision, vision for this Association and vision for organized medicine and I think it well that we pause and reflect seriously on what was said at that time in the written word.

"The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of South Carolina, and to unite with similar Associations in other States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standards of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life."

I do not see how we could have a firmer foundation, a finer objective and ideal than that set forth by our forefathers many years ago.

It has been my privilege to have been a member of organized medicine since the days of my graduation from medical school. I have been proud of that fact and shall forever be. The accomplishments of the profession to which it is my privilege to belong,

have been monumental. There is no home in America today that is not happier as a result of the medical profession. The life expectancy of each and every one of us here has been lengthened because of this profession. The profession has contributed much to the progress of this great nation, and the progress of this nation has gone hand in hand with that of the medical profession.

Disease has been, and will ever be, a twenty-four hour a day proposition. That being true, the man of medicine has never known any hours and he never will. Disease has not been submissive to new fangled legislation and new ideas. In all the chaos and all the confusion that envelopes the world and in all the misery and degradation that bothers man throughout the earth, disease has ever been man's greatest foe. There is no substitute for good health. It is only as our profession continues to fight this foe that we can ever hope to bring this boon to mankind.

In my opinion, the profession of medicine was responsible largely for the morale of the American army. If a soldier was struck he knew he would receive the very best of medical care. Last December I was privileged to hear the Major General in charge of the European Theater of the Medical Corps speak in Washington. He made this outstanding statement. He noticed in captured German wounded soldiers that the wounds practically all became infected and that in the American soldiers the wounds seldom ever became infected. After extensive study, our Medical Corps made the following observation: in the German soldier the average length of time that elapsed from the time he was struck until he received medical care was four hours, whereas the average length of time that elapsed from the time the American soldier was struck until he received medical care was twelve minutes. That is an illustration of the private practice of medicine in this country in time of war. I don't see how the profession in this country could have done more than it has done. They have ministered to the sick, they have cared for the indigent, they have been

* (This address was delivered at the Annual Banquet of the Association, Myrtle Beach, May 1, just before Dr. McLeod was inducted into the Presidency of the Association.)

pioneers in the field of public health, they have given of their best. The man of medicine has known no hours, and I am quite sure he has been imbued with a spirit of service that has been the spirit of the true physician.

And yet, in spite of this magnificent contribution of the medical profession there are in Washington today so-called social-minded politicians who think they will make a carpet of our profession over which they can ride to their own aggrandizement and glory. And I say to you if they are successful they will destroy the practice of medicine in this country as we have known it. They would bring politics into the sick room. We expected regimentation in this country under Hitler, not under a victorious stars and stripes. I say to you if this legislation should pass, it will be the opening wedge to split asunder a free America.

Let us now turn from the national scene to our own state organization. The South Carolina Medical Association is one of forty-eight state associations that form the supporting framework of the great American Medical Association. In my opinion, the South Carolina Medical Association is a great cross section and a good symbol of organized medicine. As a matter of fact, I think we in South Carolina have perhaps made the same mistake that has been made by the other 47 states, that is, we have looked too long and too often to Chicago for leadership. In turn, I think Chicago has failed to look to the individual states for guidance. It is my opinion that the South Carolina Medical Association has been an active association through the years. It has been composed of men who have not only contributed greatly to medicine but who have entered into our community life and have been our leading citizens. In the War Between the States, South Carolina physicians contributed greatly to the southern cause. In the two Great World Wars just concluded in the same generation, South Carolina has furnished more than its quota of doctors to the colors.

In my opinion the South Carolina Medical Association today is one of the very best state associations in the nation. I think this is due to the fact that we have had a very distinguished leadership in recent years in our organization and our leadership in the immediate past and the present has been outstanding. I say to you that Dr. W. Thomas Brockman has just given us an outstanding administration. He is a man of sterling integrity and honor and a man who has the philosophy of life in his soul so blended with his nature that he has endeared himself to all with whom he comes in contact.

We have been fortunate in having a secretary who, I think, is one of the leading medical association secretaries in the United States. Dr. Price is well-known in medical circles throughout this country. He has carried this association across some rough

roads. It was his vision that gave the South Carolina Medical Association and gave to the nation the first director of Public Relations of any medical association in the United States.

Our Director of Public Relations, as you know, is an attorney, Mr. M. L. Meadors, and he has done an outstanding job. He has been director of our Ten Point Program and has done well. He has attended many legislative meetings and has helped in much legislation. He is a tremendous asset, not only to this association but to our national organization as well. He is doing an excellent job and it is my opinion that each of the forty-seven other states will soon follow the lead of South Carolina in having a Director of Public Relations. It is my opinion that all forty-eight states should have had such a director thirty or forty years ago. I doubt if we had we would have found ourselves in the position which now exists, if we had been this far-sighted.

The Council of this association has been composed of a fine group of men who have carried on through the war. Dr. Frank Cain, Chairman, of Charleston, did an outstanding piece of work. I would like to pay tribute to him and to his successor, Dr. Robert Durham, of Columbia. I would like to pay tribute to the new Chairman of Council, Dr. Roderick MacDonald of Rock Hill. And, last but not least, we, in South Carolina, have had for many years a distinguished membership. That membership, of course, supports the entire structure.

Let us now turn to the beginning of a new year and analyze ourselves as individuals and also as an organization. We must recognize, to begin with, that no profession is so discussed by the public as is the profession of medicine today. It is being discussed, we might say, almost on every street corner. The public seems to sense that certain changes are to take place in medicine. As a matter of fact a certain percentage of the people seem to believe that they are soon to receive free medical care. There is criticism not only of us as an organization and of our national body, but perhaps of us as individuals also.

It has been my privilege to have attended many medical meetings, from the county society to national gatherings, and the pattern of all appears to be the same. When doctors gather at a medical meeting, they assemble and hear scientific papers read which usually interest only a few of those present. This is followed by a period of social fellowship and adjournment. There is practically nothing that emanates from our national, state, or county societies in regard to the public welfare. The economic and social features of medicine have been sadly neglected. These are the things the public has judged us by.

The national, state and county meetings should, in my opinion, devote a definite part of their programs to a discussion of the public welfare. Since the

county society is the foundation stone upon which the state and national organization is founded, we should begin with that unit. Every county society should interest itself more in public affairs and let the public know what it is thinking and doing. The county society should work in closer cooperation with the Board of Health and publicize that fact. The county society should interest itself in public education in the state and in its own communities. I say to you, the county society must take stock of itself and promote a definite public relations program. If we did this we would do much to keep the public informed. The county society holds the power and potential of our state organization. I do not think anyone should be allowed to practice in any community who is not a member of his county society.

I am tremendously impressed with the aid that this organization can receive from our Woman's Auxiliary. In looking around for ways of helping our Association I would suggest that you read Russel Cornwell's "Acres of Diamonds." We have "acres of diamonds" in our womenfolk. The ones who best understand the trials, tribulations, and ideals of the medical profession are the wives of the doctors. They have been sympathetic, they have been ambitious, they would do anything to help. The Woman's Auxiliary can do much to inject the economic and public relations feature of our organization. It is my ambition to see the Woman's Auxiliary alive and stimulated and I hope we will have 100% membership. The Woman's Auxiliary can be developed into an organization which can help us immeasurably in interpreting our plans and objectives to the public. As a matter of fact I would like to see women projected into the public life of this state. They have been enfranchised in this state many years ago, but they are barred from jury duty, therefore I don't think we can say that they are full citizens of the state. It takes intelligence to administer justice, and women should be allowed to serve on our juries. If we do so I think our courts will be much better. The court house in our community should be the most revered building in any community, next to the church. I say the women should be encouraged to help us to help our state. If every position in the world, politically and otherwise, had been held by women for the past 30 years do you think the world could have been in any worse mess than it has been in the past 30 years? I don't think so. So, I say that we have our most priceless possession with us—an organization or our wives who want to help. I do not believe we can do our best without the aid and cooperation of that organization.

One night last summer, while going home I received one of the great inspirations of my life. I tuned in the radio in my automobile and heard the voice of General Eisenhower speaking on the air from the ballroom of the Waldorf Astoria in New York. In substance, he said that America must remain

strong if we are to have peace, that he hoped that we would not make the mistake we made after the last war; that he wanted this nation to remain strong. He said he had heard regular army men accused of the fact that because they were regular army men they wanted to promote war because promotions were easier for army men in time of war than peace. He stated that he himself had been accused of wanting to have war. He said nothing could be further from the truth, that no man who was human could possibly visit a fresh battlefield and see the grotesque forms awaiting burial and have anything but peace in his heart and soul. The army doesn't want war, but America must remain strong. And then he made this outstanding statement. "Weakness can cooperate with nothing." That applies to us as a nation, to us as a state, to this Medical Association of ours as an organization, to you as an individual. I ask you to remember the words of General Eisenhower, "Weakness can cooperate with nothing."

I do not know of any man in all the world who to me typifies as good a citizen as does the medical missionary. He is the one man who renders aid and comfort to his fellowman physically, intellectually and spiritually. The true physician must be strong spiritually.

In this day when man has harnessed the power of the atom, that is capable of destroying this world, I think it would be well for us to pause for just a moment and reflect on what to me are the finest words of the age—words that I believe will go down ringing through the years and echo and re-echo through succeeding generations. I refer to those immortal words of General MacArthur when he was aboard the Battleship Missouri in Tokyo Bay. I cannot quote his exact words but this was his message to the world. "Man since the beginning of time had always sought peace; various instrumentalities have been devised to settle disputes between nations but they have all failed; they have been successful in settling disputes between individuals but when it came to settling disputes between nations nothing had been successful; man had always resorted to the crucible of war, and war is now so utterly destructive that unless an equitable system of peace is devised the Battle of Armageddon is at the door. Any material progress must be through the spirit. If we are to save the flesh it must be through the spirit." That is from that great warrior of the South Pacific, battle-worn as he was. That is his vision of the future.

This is a grand and glorious organization, but we want a stronger and better association. We want one hundred percent membership of the practicing physicians of this state. We want a one hundred

percent Woman's Auxiliary, and we want to all march together in cadence, strong, courageous, confident in a free America. I say to you in conclusion, stop and think what you can do, what you can contribute and may you ever remember this:

"Life is the mirror of King and slave,
'Tis just what we are and do,
Give to the World the best that you have,
And the best will come back to you."

The Rheumatic Fever Program in South Carolina

Submitted by Staff of the Rheumatic Fever Program:

M. W. Beach, M.D.—Pediatrician and Director
B. Owen Ravenel, M.D.—Assistant Pediatrician
J. A. Boone, M.D.—Cardiologist
Mrs. Marian Coburn—Medical Social Worker
Miss Mildred E. Blackwell, R.N.—Public Health Nursing Consultant
Miss Marjorie Almand—Clinic Clerk

On February 1, 1944, the South Carolina State Rheumatic Fever Program was established according to the general principles and policies outlined by the Crippled Children's Division of the Children's Bureau of the Department of Labor. The real purpose of the program was to discover the number of rheumatic fever patients in a limited area of the state and to ascertain whether or not there was a need for continued diagnostic and therapeutic services. This disease had been gradually gaining recognition and importance in other states and it was evident that South Carolina should give more attention to the finding of its rheumatic fever cases. Since the program was to be one of demonstration and since the budget was limited, the area to be served was confined to seven counties: Horry, Georgetown, Berkeley, Charleston, Colleton, Florence and Dorchester, with the health department in each county agreeing to assist in case finding and follow-up care. This area was most sensibly chosen because the facilities at the Medical College and Roper Hospital were available in Charleston and those of the Crippled Children's Convalescent Home, in Florence. It followed quite naturally that headquarters should be established in Charleston.

The program is administered under the supervision of the Crippled Children's Division of the State Board of Health. Part-time services of a pediatrician, who is the director, an assistant pediatrician, a consultant cardiologist, a roentgenologist and the full-time services of a public health nursing consultant, a medical social worker and a clerk are paid for by the Crippled Children's Division.

Children and adolescents under 21 years of age are eligible for the diagnostic, treatment and follow-up services of the program. If hospital care is nec-

essary, the patient is admitted to Roper Hospital. Convalescents who cannot receive adequate care at home are frequently placed in the Crippled Children's Convalescent Home at Florence.

During the two years that the program has been in operation there have been interesting developments. As physicians, nursing and social agencies, school teachers and the public in general have become informed about the program, they have grown interested and eager to refer patients. Patients have come from 25 of the counties in the state. They are referred by special medical forms to the State Crippled Children's Division. Once the forms are approved, the patient is accepted by the clinic. Each Thursday a clinic is held in the Alumni Building of the Medical College in Charleston and eight patients are seen; some new and some old. The pediatrician and assistant pediatrician, with consultant services of the cardiologist, thoroughly examine each patient. Special diagnostic procedures, such as X-rays, laboratory tests and electrocardiographic examination are utilized. Within recent months an increasing number of patients have been referred by private physicians for diagnosis only, for complete care, or for diagnosis and treatment in conjunction with the clinic. It is startling to note that of 162 patients referred to the clinic from 2-1-44 to 2-28-46 for diagnosis and treatment, only 89 actually had rheumatic fever.

The patient's first visit to the clinic is the most important, inasmuch as his condition requires painstaking, often tiresome, investigation. Every effort is made to provide for the comfort of each child. Ordinarily a medical history is sent in by the referring doctor or nurse. This is a time-saving device and gives the clinic doctor at once most of the necessary

background information. If a medical history is not sent in, it is obtained by the public health nursing consultant either several days before the patient's appointment, or, if the patient comes from out of town, on the same day.

Usually the clinic nurse weighs the patient, takes his temperature and collects a urine specimen. The doctors then examine him and dictate their findings and any treatment recommendations to the clerk. After the examination the public health nursing consultant instructs the patient as to where to go for electrocardiographic, X-ray and laboratory procedures. Various procedures are explained to the patients in order to establish their confidence and decrease their fear and anxiety.

Both the public health nursing consultant and the medical social worker are present at each clinic. The nursing consultant acquaints herself with the health problems of the patients and their families and helps to meet them. Usually, she is familiar with the care the child receives at home, the type of diet, sanitary methods used, illness of other members of the family, etc., and can inform the doctor about these matters. Since she is present at the patient's examination, and learns the medical problems involved, she is in a position to interpret the doctor's instructions to the families and to the county nurses who give nursing care and health instructions in the homes outside of Charleston County.

The medical social worker, by collecting data from social agencies which know or have known the patient's family, by visiting the home, school, etc., before the child comes to clinic is able to present to the doctor a picture of the child's family and environment, with an estimation of the family's ability to meet the physical and emotional needs of a sick child. In the clinic she learns about the child's particular medical problem, endeavors to help the family with social problems connected with the medical conditions and participates in plans for the patient whenever the social situation has bearing on the medical plan. Knowledge of the relationship between the medical and social factors affecting the child's care enables the community's social agencies to understand the social implications of the medical condition and to work more smoothly with the professional staff and various agencies in providing for the child's care.

Patients who are acutely ill are admitted to the pediatric ward of Roper Hospital, where they remain under supervision of the program's pediatricians. Once the child improves, acute symptoms subside, and it is no longer necessary to have hospital care, the patient usually requires an extended period of bed rest. The pediatrician, public health nursing consultant and medical social worker decide among themselves whether his home is adequate or can be made so with a little assistance. If it is suitable,

the patient is transferred to it and requested to continue under clinical supervision at regular intervals. The nurse visits the home frequently, if it is local, to check on his progress and care, medicine supply, to draw blood samples, etc. If the patient lives at a distance, the cooperation of the county nurse is elicited in carrying out the supervision. Reports of visiting county nurses are sent to the nursing consultant in typewritten form.

In her turn, the medical social worker has the responsibility for supervising the child's convalescent care from the social viewpoint and for bringing about, either through the family or through interested agencies, social and environmental readjustments necessary to the welfare and recovery of the child.

For colored home-bound rheumatic fever patients in Charleston, the city schools have provided one visiting teacher. She visits each child three times a week. No teacher for the white children has been obtainable and this is one of the most outstanding needs of the program's ideal plan of treatment. Children who must remain on bed rest for long periods of time, progress much faster if their minds are wholesomely occupied in keeping up with their regular school lessons. As yet no teachers are available in the counties.

If the home of a patient is not suitable and cannot be made so for the convalescent care of the patient, perhaps for economic, social or psychological reasons, care is then provided in the Crippled Children's Convalescent Home in Florence. Both white and colored children are accepted at this institution. Approximately a total of 12 to 15 rheumatic fever patients can be cared for there at one time, depending on the general turnover for the home as a whole and the demand for beds. An effort is made to keep the rheumatic fever patients in wards by themselves, rather than mixed with orthopedic patients. The latter are allowed and urged to undertake physical activity which is undesirable in the early stages of rheumatic fever. Most of the children at the Convalescent Home remain there for an average of eight months to a year. After being on bed rest for about four to six months, they are allowed out of bed for increasing lengths of time and graduated exercise. Special emphasis is placed upon the intake of a well-balanced diet with supplementary vitamins, on good dental care, a minimum of emotional disturbance, maintenance of close family ties, adherence to a regime of rest and freedom from respiratory infections. Patients who improve sufficiently to be able to withstand a small amount of exercise are allowed the privilege of attending school. Their beds are wheeled daily to a central classroom where individual and group instruction is given. Along with his school work and rest, each child is taught how to take care of himself and live within the limitations imposed upon him by rheumatic fever. The progress of each patient is determined once a

month when the entire clinic staff visits the Convalescent Home to examine the patients.

When a patient's rheumatic infection becomes stabilized in the inactive stage he is discharged to his home, unless a different plan of care has been agreed upon for medical or social reasons. Prior to his discharge the medical social worker and nursing consultant study the home conditions, either personally or through local social or nursing agencies, and initiate any necessary readjustments preparatory to the return of the patient. Once the child returns to his home, he is observed carefully for any recurrence of his infection. He comes to the clinic at intervals of six weeks to three months and is supervised at home, meanwhile, by the public health nursing consultant or county nurse. The medical social consultant continues her interest in the social situation and is aware of any difficulties arising to prevent proper care. She is frequently called upon to find a home teacher, seek welfare assistance, interpret the patient's condition to school principals, vocational rehabilitation supervisors and various interested social agencies.

Each patient on the rheumatic fever program is technically on the program until the age of 21, unless he is uncooperative, moves away, or dies. Because he may have a medical record in as many as three places (Roper Hospital, the Convalescent Home and clinic) a complete record is kept in the clinic files. Abstracts of hospitalization are included and all dictation from the clinic and Convalescent Home in chronological order. Every record includes medical, nursing and medical social reports, as well as laboratory information. Pertinent correspondence is attached to the chart, but bulky letters, such as medical social summaries, etc., are filed in separate folders. All records are typewritten to insure neatness and minimize space needed.

To coordinate information about various patients and to discuss medical, nursing and social aspects of care of individual children presenting special problems from day to day, the pediatrician, nursing consultant and medical social worker meet daily. By means of these conferences, it is possible to keep posted on the progress of many patients who come to the clinic often for laboratory work, but seldom for physical examinations.

The Rheumatic Fever Program is now in its 3rd year. As previously stated, the clinic was set up in the Alumni Clinical Building of the Medical College of South Carolina because of the available advantages offered in this vicinity in staff, clinical material, laboratory and hospital facilities. This clinic has a two-fold purpose. It functions in the capacity of a diagnostic and therapeutic center. Its facilities are available to anyone who is less than 21 years of age and is suspected of having rheumatic fever. Physicians may refer private or indigent

patients for diagnosis or treatment. This service is available to all practitioners of medicine in South Carolina. It may be of some interest to discuss with you the patients seen in this clinic during the past 2 years. The total patient load has been 162. Of this number, 68 were white—37 males and 31 females. The colored patients number 94—41 males and 53 females. From these figures you will note that the colored females and white males dominated the picture. Grouped according to age, 74% of the total number were in the 7 to 15 year bracket. It is of more interest to note that of 162 patients examined, only 81 definite and 8 probable cases of rheumatic fever were found—approximately 54%. In other words, 46% of the patients seen in the clinic were non-rheumatics. These patients were found to be suffering of various ailments. Prominent in this category were tuberculosis, syphilis, sickle cell anemia, congenital anomalies and mental disturbances. If a more adequate case screening had been instituted, this load would have been lessened.

Age*	1-3	4-6	7-9	10-12	13-15	16-18	19-21	Total
White male	0	6	14	9	4	3	1	37
White female	0	3	10	7	9	1	1	31
Negro male	1	5	8	11	9	6	1	41
Negro female	2	11	14	16	9	1	0	53
Total	3	25	46	43	31	11	3	162

Age, sex and race distribution of the total caseload of 162 patients known to the South Carolina Rheumatic Fever Program from 2-1-44 through 2-28-46.

*Age at admission to the program, figured to the nearest birthday.

In the rheumatic fever group of 89 patients, we note that there were 30 white—17 males and 13 females; 57 colored—27 males and 32 females. The age group varied from 1 to 18 years. There were 2 cases in the 1-3 year bracket; 17 in the 4-6 year bracket; 21 in the 7-9 year bracket; 27 in the 10-12 year bracket; 17 in the 13-15 year bracket; and 5 in the 16-18 year bracket. Ninety-two per cent of all the rheumatic cases seen in this clinic were in the 4-16 year bracket.

All proven rheumatic fever cases are classed as being in the active or the inactive state. The active cases are usually of recent date or have relapsed. They are now undergoing a destructive physiopathological state—the degree and duration varying with the individual case, but this destructive process may

Age	1-3	4-6	7-9	10-12	13-15	16-18	19-21	Total
White male	1	4	4	5	2	1	0	17
White female	0	2	5	2	4	0	0	13
Negro male	1	4	6	7	5	4	0	27
Negro female	0	7	6	13	6	0	0	32
Total	2	17	21	27	17	5	0	89

Age, sex and race distribution of the 81 rheumatic and 8 questionably rheumatic patients still on the program as of 2-28-46. (Non-rheumatics, patients who have moved out of the state, the deceased, etc., have been excluded.)

be alleviated by complete bed comfort, adequate nutritional diet, removal of handicaps and the therapeutic use of sodium salicylate. If the diet is on the inadequate side, it should be supplemented with vitamins. This regime may require from 3 to 9 months, and, during this time, may tax the ingenuity of the staff and parents. Unless there is complete harmony, the whole effort may be lost and the child's health sacrificed.

The rheumatic fever cases who are in the inactive state present no less a problem; for if the heart has been damaged by a previous attack, we know that each subsequent episode will add materially to the already damaged organ. These repeated attacks soon destroy and disrupt the normal mechanism and deplete the heart's reserve, and, thereby, cause a state of heart failure. This failure may be so mild until the child only complains of exertional dyspnea or of tiring easily; or it may be so severe as to produce a profound state of anxiety, dependent edema, orthopnea, shock and death.

The Rheumatic Fever Clinic has on its program

as of this date, 16 active, 15 convalescent and 58 inactive cases. The active cases are confined to bed with all activities restricted. They are given the best balanced diet that circumstances will permit, and frequently this is supplemented with vitamins. Every effort is made to pacify these patients. We try to induce in them a state of happiness. We try to arouse and fortify their courage so that their morale may be built on a high plane. These prerequisites are essential for their future health and happiness. These patients are given therapy in the form of sodium salicylate—usually 1 grain per pound body weight per 24 hours and it is administered in equal doses every 4 hours. Enteric coated tablets or pills have been found most satisfactory for this purpose. There has been little gastric disturbance with this regime. Sodium bicarbonate is not used, because it lessens the therapeutic value of the salicylates. A close watch is kept on the patients for adverse states that may occur. We know that some patients react adversely to the salicylates, and, at times, may be poisoned from this drug. The blood and urine are frequently examined and detailed study made when necessary. The more common procedures used are red and white counts, hemoglobin, sedimentation rate, blood level percentage of sodium salicylate or sulfadiazine and typing for transfusions. Also, they are given the advantage of x-ray and electrocardiographic studies. At this point, it may be of some interest to scrutinize more closely blood findings recorded on these patients before and after being placed on sodium salicylate and sulfadiazine. You will note that the average total and white count and hemoglobin did not differ materially after instituting salicylate therapy. Before taking the drug the highest W. B. C. was 20,500 and the lowest was 5,800—the average 9,489. The average differ-

BLOOD EXAMINATION BEFORE ADMINISTRATION OF SODIUM SALICYLATE

	Hgb. before sal.	Leuc. before sal.	Lymph. before sal.	Endoth. before sal.	Polys. before sal.	Eos. before sal.	Bas. before sal.	Sed. rate before sal.	Av. sal. con.
Highest	13	20,500	67	8	79	10	.8	28	40.5
Lowest	8.6	5,625	17	0	30	0	0	9.5	0
Average	11.56	9,489	39.8	3.2	54.6	2.4	0.2	19.9	17.9

BLOOD EXAMINATIONS AFTER ADMINISTRATION OF SODIUM SALICYLATE

	Hgb. on sal.	Leuc. on sal.	Lymph. on sal.	End. on sal.	Polys. on sal.	Eos. on sal.	Bas. on sal.	Sed. rate on sal.	Months on sal.
Highest	14	14,625	64	5.8	63.5	10	2.5	39.8	20
Lowest	10.3	4,500	28.6	1	24	0	0	7.5	1
Average	11.7	8,363	45.6	2.8	48.7	2.4	0.4	16.4	7.4

BLOOD EXAMINATIONS BEFORE SULFADIAZINE

	Hgb. before s'dia.	Leuc. before s'dia.	Lymph. before s'dia.	End. before s'dia.	Poly. before s'dia.	Eos. before s'dia.	Bas. before s'dia.	Sed. rate before s'dia.
Highest	13.1	14,200	55.8	11.6	67	10	1.5	26.3
Lowest	7.3	5,613	31.0	0	37.8	.5	0	8.8
Average	11.7	8,053	41.9	3.3	52.2	2.1	0.3	15.7

ential W. B. C. was: polys. 54.6%, lymphocytes 39.8%, endotheliocytes 3.2%, eosinophils 2.4%. The average hemoglobin was 11.56 gms. After continuing this form of therapy from 1 to 11 months, the blood picture did not materially change. The average white blood count was 8,363, polys. 48.7%, lymphocytes 45.6%, endotheliocytes 2.8%, eosinophils 3.9%. The average hemoglobin was 11.9 gms.%. Therefore, it is evident that this drug had little detrimental effect on the blood producing system. The sedimentation rate in this group varied from 10 to 30 mm. per hour, with an average of 19.9 mm. per hour, before receiving salicylates. However, the response to this type of therapy when judged by the average fall (16.4) of sedimentation rate has been somewhat disappointing. But if we analyze these findings a little further it becomes quite evident why the response was disappointing. The

crowded homes. The blood findings in these patients taking sulfadiazine therapy were very similar to the blood picture before instituting this form of therapy. You will note that there was a slight reduction in the total white count and a slight shift in the polys. and lymphocytes. The average count was as follows: hemoglobin 11½ gms., W. B. C. 7,463, polys. 47.9%, lymphocytes 46.7%, endotheliocytes 2.7%, eosinophils 2.2%, basophiles 5%. During this form of prophylactic therapy there was less fluctuation of sedimentation rate, which averaged 15.7 mm. before and 12.2 mm. during the treatment. The sulfadiazine concentration in the blood varied from .75 to 5.2 mg.% and averaged 2.8 mg.%. We found it necessary to discontinue the sulfadiazine on only two patients. In one case the urine contained a trace of albumen, an occasional pus cell and a few sulfadiazine crystals.

BLOOD EXAMINATIONS AFTER SULFADIAZINE

	Hgb. after s'dia.	Leuc. after s'dia.	Lymph. after s'dia.	End. after s'dia.	Poly. after s'dia.	Eos. after s'dia.	Bas. after s'dia.	Sed. rate after s'dia.	Mo. on s'dia.	S'dia. con.
Highest	13.2	10,403	60	6.2	65	9	4	27	7	4.64
Lowest	10	4,757	36	0	37	1	0	6	1	.75
Average	11.5	7,463	46.7	2.7	47.9	2.2	0.5	12.2	3.8	2.8

majority of cases who did not respond to this type of therapy either had a salicylate blood level below therapeutic bracket or else did not show any drug blood level. The salicylate blood level varied from 2 to 40 mg.%, with an average of 17.9 mg.%. This drug has been administered to some patients from 1 to 20 months, average 7.4 months.

From clinical and laboratory standpoint, there has been no evidence of kidney damage. Since it is thought that the sulfonamides may act as a prophylactic agent against streptococcal infections, and, in this way, lessen the possibility of the inactive rheumatic fever patient's becoming active. We have been administering sulfadiazine to a group of patients who appeared to be in the inactive phase of this disease. They are given from ½ to 1½ gms. of this drug daily. A close follow-up is maintained by staff, including frequent laboratory determinations. The blood and urine are studied before and after these patients are placed on this regime.

The average blood findings before instituting sulfadiazine prophylactic therapy were as follows: hemoglobin 11.7 gms., W. B. C. 8,053, polys. 52.2%, lymphocytes 41.9%, endotheliocytes 3.3%, eosinophils 2.1%, basophiles .3%.

The urinalyses done on these patients were found to be in the normal range. These cases were then given sulfadiazine prophylactic therapy for a period of time varying from 1 to 7 months—average 3.8 months. The staff was led to believe that this type of therapy has been beneficial to certain groups, and has lessened the incidence and duration of the upper respiratory infections, which have been so prevalent in this group who are living in very meager,

It is extremely difficult to evaluate the damage done to the rheumatic fever patient by the forces of poverty which cause him to live in overcrowded, poorly and inadequately constructed and kept homes where slovenly habits overshadow all desire for betterment. He is unconcerned about hygiene and sanitation, but always alert for anything which may satisfy the desire for food. There can be little doubt that nutrition plays an important role concerning the welfare of the rheumatic fever patient. We believe that this point has been fully demonstrated, but probably a more detailed discussion of the home conditions and the nutritional status of the patient on this program will be worthwhile.

Weight alone is not all conclusive evidence of improvement in a patient's condition, but it is one of the few tangible factors which can be tabulated.

The weight gain of the 81 definitely diagnosed rheumatics and the 8 questionable rheumatics now under clinical supervision, as of 2-28-46, was taken from the weight on admission to the Rheumatic Fever Program through the last weight given on the chart. The time interval varies because of the different lengths of time the various patients have been on the program. In many cases the weight gain covers the total period the child has been on the program. In other cases it does not, because the child may have been to clinic, for example, in December of 1945 and weighed then, and may have come to the laboratory once every two weeks since then, but never weighed again.

It is impossible to say much about the weight of the convalescent patients, most of whom are at the Cripple Children's Convalescent Home, because scales

have not been available and the children have not been regularly weighed as they should have been. From general observation, however, and from comparing the rise and fall in weights of those whose weights are known, it appears that they gain very slowly and have comparatively poor appetites, they tire of "institutional" foods and being away from home, and some miss the food at home, etc. Frequently upon return home, with the disease in the quiescent stage, they gain unusually large amounts of weight almost immediately.

Some significant points about weight gains seem to be as follows:

1. Children in the active and convalescent stages of the disease gain slowly and very little over a long period of time.

2. Children in the age brackets up to about 8-10 years of age gain much more slowly than children in the adolescent stage. Adolescents may gain anywhere from 10 to 35 lbs. in a 16 to 24 month period. (Two colored boys of age 16 gained 30 and 34½ lbs. in a two year period. A 14-year-old white girl gained 30 lbs. in two years; another, 24 lbs. in 13

has an intercurrent infection or setback and suffers from loss of appetite.

5. For patients in indigent families where an adequate diet cannot be provided, it is sometimes possible to obtain milk and additional foods through the use of local welfare resources.

6. The psychology of eating must be considered in studying rheumatic fever patients because some who are on limited activity due to the activity of the disease or amount of heart damage may use eating as an emotional outlet or for satisfaction. They cannot enter into any normal activity and, therefore, eat excessively as one means of obtaining pleasure in life. This makes them gain too much and adds an extra burden to already damaged hearts. Attitudes of parents who take care of these children may influence eating habits, often deleteriously. A child whose appetite is catered to at home by an overanxious mother may be a feeding problem at the convalescent home, refuse to eat, and gain almost nothing in many months. Both under-eating and over-eating are problems which have to be faced in treating these children.

WEIGHT GAIN OF 68 PATIENTS ACCORDING TO NUMBER OF MONTHS ON PROGRAM Weight Gain in Pounds

1 mo.	2 mo.	3 mo.	4 mo.	5 mo.	6 mo.	7 mo.	8 mo.	9 mo.	10 mo.	11 mo.	12 mo.
1	1	1½	1¾	½	7½	6	2	3¾	11½	2	6
½		1	1¼	3	5	14		3	¾		5½
4		3½	2	3	3			10	1		20
					1			7			5
											12
13 mo.	14 mo.	15 mo.	16 mo.	17 mo.	18 mo.	19 mo.	20 mo.	21 mo.	22 mo.	23 mo.	24 mo.
24	6½	5½	29¾	16	26½	12	28	3½	26	36½	19
5½	24½	14	3¾	10	11½	15½		9½		16¼	30
1		4	2½		34						11½
5½		6			6						30
		13			9						34½
		7									

months.) In contrast, preschool age children frequently gain at a rate of 1 lb. in 10 months or 4 lbs. in 15 months, or 3 lbs. in 9 months. Occasionally, failure to gain is associated with other diseases or conditions, like cleft palate or sickle cell anemia, etc., which the patient has in addition to rheumatic fever.

3. Contrary to what one might think, one cannot say there is any direct relationship between the type of care the patient gets at home, especially in regard to the adequacy of diet, and his weight gain and general nutritional status. Many patients whose diets are known to be grossly inadequate, whose families are indigent, not especially interested in the welfare of the child, unable to provide the milk and other necessary foods, etc., gain large amounts of weight when it would seem impossible under the existing conditions. Probably this weight is due to the large intake of starches.

4. Weight gains, on adequate diets prescribed in clinic, together with vitamin supplements, are usually steady and gradual once they start, unless the patient

Statistical analysis of the weight gains of 89 patients now under supervision showed that the average weight gain is 1 lb. per month. Only two patients lost weight after several months on the program. One boy lost 1½ lbs. in ten months. He is a patient at the Convalescent Home and weekly visits from his mother who criticizes the food there have their effect on him. The other child is a girl who is just becoming adjusted as a new patient at the Home. She has had an upper respiratory infection as well as some minor behavior difficulties and has lost 3 lbs. in 7 months, most of it in recent weeks. Three other convalescent patients have gained nothing in 6 to 12 months on the Program. Two patients in the inactive stage of the disease have gained no weight in 3 months and 5 months respectively. Eleven of the patients were weighed only once and cannot be counted in the statistics. They are either new patients who have been to clinic only once or old ones from long distances who are seldom examined. The weight gain of 3 patients is unknown because they have been in the hospital or Convalescent

Home and not had a regular check on their weight and this information is not available.

It is impossible to make a statistical report on the home conditions of the rheumatic fever patients because data on home conditions is always subjective and based on the opinion of the visitor to the home. However, from what is known it is possible to generalize and speculate.

Approximately one-fourth of the patients come from homes where public assistance is being given. Most of these homes are extremely poor from the physical and sanitary viewpoint. The children are exposed to poverty, inadequate diet, slovenly habits, bad housing conditions, etc. On the other hand, in a few of these homes receiving welfare assistance, relief is used constructively and the family makes an honest effort to improve their way of life within the financial limitations imposed on them by circumstances.

About 5% of the patients come from average, comfortable homes where there is a steady income which provides a good diet, a decent house with modern conveniences, a few luxuries, and a promise of satisfactory care for the patient. Some of these patients have been referred to us by private physicians, either for diagnosis only, diagnosis and treatment, or diagnosis and treatment in cooperation with them. This group is enlarging rapidly, as more private physicians become familiar with the program and how it can be useful to them.

The remaining 70% of the patients come from what would be called "low middle class" homes. Usually, there is a small, dependable income, which provides a small, frequently overcrowded, house with very few conveniences, such as a bathroom and running water. In most cases, the family has made plans to add rooms to the house in the future. Food is a large item for these families because frequently there are a number of children and a large amount of food is needed. Many families have a garden, raise a few chickens and pigs, provided they live in the country or have a little land available.

Despite all the differences in home conditions to be seen in connection with the patients there is no correlation between the conditions of the home and the activity or inactivity of the patient's disease. It does not happen that under certain home conditions, given an intelligent set of parents, with the patient in such and such a stage of the disease, if such and such treatment is carried out in the home such and such results can be expected. When one thinks he has taken everything into consideration and believes that he has best of circumstances provided for the child, there is apt to be a totally unexpected result. It is, of course, possible to anticipate with a fair degree of accuracy that, under certain existing

conditions, a child is going to become worse, have a relapse, etc., but it is more difficult to predict improvement. In any case, one can never review a child's care or estimate his chances for recovery without figuring in the very important social elements—for the interaction of individuals in the patient's family, the attitude of the patient toward his family members and theirs toward him, attitudes toward disease, etc. However, in the final analysis what is really important, given two different rheumatic fever patients under the same home conditions, is the individual physical reaction to that disease. We have seen patients from fine homes where they had all sorts of good care and attention do poorly because of an innate inability to fight the disease. Conversely, there are children on the Program who come from the worst type of slum home where there is ignorance, poverty, filth, etc., and yet they will improve remarkably; this does not mean that one should assume that there is no need to make an attempt to provide for every patient an adequate diet and the other necessities of life. Each child should have the benefit of all the physical aids that can possibly be provided—food, clothing, shelter, medical attention, parental guidance and discipline, home instruction, if he is a bed patient, etc., because it is undoubtedly true that these things increase his ability to combat the infection and speed recovery, which is usually alarmingly slow.

With the Program growing by leaps and bounds, it is only a matter of time before there will be a demand for a state-wide Rheumatic Fever Program. Already, children are travelling long distances to attend the clinic in Charleston. Every effort is made by the staff to inform county health officers, public health nurses, physicians, welfare workers, teachers, school principals and the general public about the program. Interested professional and lay people are urged to refer known rheumatic fever patients to the Crippled Children's Division. With the rapid expansion that is accompanying these efforts, however, come innumerable problems. There is the need for more clinics in different sections of the state, services of home teachers and an occupational therapist, an additional public health nurse in the clinic and a more developed foster home program for placement and care of children whose homes are unsuitable. Probably most important is the need to establish case finding clinics in the principal metropolitan centers of the state—Columbia, Greenville, Spartanburg, Anderson and Florence, and then to provide an adequately equipped and staffed convalescent home located near the main diagnostic clinic.

In any case, the Program has demonstrated the serious need for its existence and the demand for its continued development.

Annual Meeting House of Delegates

South Carolina Medical Association

TUESDAY—APRIL 30, 1946

DR. W. T. BROCKMAN, President, presiding

Dr. Brockman: The meeting of the House of Delegates will come to order. We will have a report of the Credentials Committee.

Dr. Sease: There are 60 delegates present.

REMARKS BY PRESIDENT

My Friends and Fellow Physicians:

I would like to urge:

1st. Basis Science Law Legislation.

2nd. Veterans Administration agreements with county and state units to care for service connected Veterans at home, by home doctors, home hospitals.

3rd. Urge concerted effort to push recently enacted Blue Cross Act into practical usefulness in every section of the state.

4th. Determine how Organized Medicine must influence Hospital Commission to secure Hill Burton Aid. Nowhere is the value of the ancient proverb of the bundle of sticks better illustrated than in organized medicine today.

Most of us here tonight grew up in a practice and profession whose mold appeared fixed and unchanging. Our duty seemed clear. It was to take care of the sick and keep up with the rapid advances of scientific medicine had to offer. It seemed to us that all of our time and energies were required to attain that goal.

We have tried to keep our charges within the ability of the patient to pay and we have, likewise, given a considerable share of our time and thought, individually, to charity services for which we asked and expected no financial return, because we have all understood such services to be part of the obligations of medical practice.

We have felt that the social ills which were reflected in the failure of some people to secure good medical service were no more the responsibility of the doctors than of the lawyers, businessmen or government officials.

There are a great many people in the United States who believe honestly that an over-all plan for better distribution of medical services should be the first step in the solution of our most pressing social problems. It is true, for the most part, that these people are not practicing physicians; but they are vocal and eloquent. Editors and bureaucrats lend them a ready ear. Many intelligent people listen to them seriously.

It is unfortunate that so many of these earnest reformers believe that government control of medical services is the answer to the problem. As practicing physicians, we are convinced that government control would destroy private practice entirely and place the care of the sick in the hands of the politicians. But it is also unfortunate that medical men, while fighting a thing which they honestly believe to be a threat to the public welfare, should also have been jockeyed so often into an appearance of stubborn self-interest.

It is a fact that the average health of the people of the United States is good; that our medical services in general are the best in the world today.

It is a fact that in most sections of the United States any man, woman or child who seeks it can get good medical care in case of need, and that better care is available for the sick poor man than anywhere else on the face of the globe today. It is also a fact that the cost of good medical service has mounted greatly in the last fifty years and that people of small income are often deterred from getting all of the care we would like to give them because the costs are too high. We know that there, too, the fault does not lie with the individual doctor. But no good will come from denying the fact that the problem exists. It is a problem which we, as doctors, should be the first to endeavor to solve.

We are now engaged in a great and necessary fight against the legislation introduced by Senators Wagner and Murray and Representative Dingell which provides for compulsory medical and hospital insurance as part of the social security protections of the United States.

The pernicious aspects of this legislation will not be discussed here as they are well known to all of you. It is essential to the future of medicine in the United States that we oppose it by every means at our disposal, as public-spirited men and women.

Let us fight compulsive legislation with all our might. But let us study our situation well in our state and be the first—not the last—to advocate a sound, public-spirited health and medical policy.

The Chair: We will now have the report of the Director of Public Relations and Counsel, Mr. M. L. Meadors.

REPORT OF THE DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

A large portion of the work of the Public Relations Office, of necessity is covered in the Secretary's report. We will attempt to avoid unnecessary repetition and so far as possible devote this report to items not presented elsewhere.

Chicago Meetings

Among the first of our activities since the meeting of the House of Delegates in September was the attendance, in company with Dr. James McLeod, president-elect of the association, of a Public Relations Conference called and held under the auspices of the American Medical Association in Chicago, Illinois, in October, 1945. The purpose of the conference, as indicated, was directly in line with the work of our department and the discussions and activities were most helpful. The meeting was divided into a number of roundtable discussions on various subjects of interest to the profession, and culminated in a general meeting on the final day at which resolutions from all the smaller groups were considered and adopted, some with amendment.

At this meeting, as a result of resolutions presented

by the group having the subject under discussion, a conference on Medical Prepayment Plans was arranged and called for November 29 and 30, 1945, immediately preceding the annual meeting of the House of Delegates of the American Medical Association. As has been reported through the pages of the Journal heretofore, Dr. McLeod was on the Resolutions Committee from which emanated the suggestion for the calling of the November conference. Our interest and activity in this connection was heightened by the appointment of Dr. McLeod and your Director on a committee headed by Dr. A. W. Adson of Rochester, Minnesota, to draw up the agenda for the November conference. During the intervening weeks considerable time and study was devoted to preparation of proposed subjects for discussion. The plan followed by Dr. Adson was that of having each member of the five-man committee submit proposals, and it was extremely gratifying to us that a majority of the subjects and speakers suggested by us were included on the final draft of the agenda and presented accordingly at the conference in November.

On November 30th and December 1st, we attended with Dr. Julian Price, as delegates from the South Carolina Medical Association, the National Conference on Prepayment Medical Care Plans. Dr. Price was on the formal program and submitted a comprehensive plan for a national coordination of prepayment plans. The program of this conference included discussion of practically every type of plan which has been suggested within the past several years for the prepayment of medical care. The advantages and disadvantages of the service and indemnity plans were fully discussed, together with the desirability of one national organization for the purpose, as opposed to that of a Federated system of plans on a state or other geographical basis with definite standards. Out of this conference grew the appointment of a committee to prepare and submit a plan to the Board of Trustees of the American Medical Association, and further developments are in progress. On the final day of the conference we had the opportunity to actively participate in the discussion of some of the subjects under consideration.

In February 1946 we attended the Conference of Secretaries and Editors, accompanied by Dr. S. G. Spivey of Columbia, who went to attend a meeting of the Exhibitors at State Medical Conventions. Through all of these meetings we have had the opportunity to become personally acquainted with doctors and others, outside the profession, from all parts of the country, to compare experiences, obtain the benefit of their suggestions and pass along to them items of interest from our own experience in South Carolina, and have made the contacts and laid the groundwork for future cooperation and coordination of the activities of this association with those of other states and the national organization. The trips for awhile were rather frequent and arduous, but there is no question of their value and the procedure was directly in line with our recommendation at the time of our last report.

About the same time, and doubtless as a result of our contacts in Chicago, we were invited to address the organization of Secretaries and Presidents of the County Medical Societies of Indiana, in Indianapolis, on Sunday, January 13th. We were graciously received by Mr. Tom Hendricks, Executive Secretary of the Indiana State Medical Society, and part-time Secretary of the Council on Medical Service and Public Relations of the American Medical Association. The subject we were requested to dis-

cuss was "The County Medical Society in the Present Crisis," and we were glad to take advantage of the opportunity to outline a number of things which have been undertaken and some of which have been accomplished in South Carolina.

Committee on Returning Medical Officers

As a result of a resolution adopted by the House of Delegates in September, a committee of doctors was appointed, with Dr. W. L. Pressley, of Due West, as Chairman, for the purpose of assisting in the location and relocation of medical officers returning from the armed forces. Dr. Pressley, as a result of his work as head of the Procurement and Assignment Service, had available the data on the men returning and through our office we undertook to find the locations in South Carolina where doctors were needed. One doctor in each county was selected and a letter addressed to each of the forty-six requesting him to advise us whether or not any community in his county was lacking in professional services and if so, the type needed, whether general or specialist, and the specialty involved. The doctors were requested to consult with their colleagues and to give their advice on the basis of their collective opinion. Active response was received from fifteen of the doctors contacted. Most of those who replied suggested the need of physicians and specified the type desired. This information was immediately relayed to Dr. Pressley, Chairman of the Committee, and processed from that point by his office.

Hospital Survey Committee

As a result of other action by the House of Delegates, we served on the committee from the association on the problem of a hospital survey. This committee met with a group representing the State Hospital Association and after considerable difficulty worked out with them a compromise agreement for recommendation to the General Assembly, after it became evident that passage of a bill delegating the work of the survey to the Department of Public Health, in line with the action of the House of Delegates in January, could not be passed. The compromise agreed upon between the two associations likewise failed to find favor with the lawmakers and the final result was passage of a bill placing the matter in the hands of the State Research Planning and Development Commission. It may be recalled that in our report of last September, it was suggested that this Commission provided an ideal set-up for making the survey, and, in our opinion, the ultimate result was a very satisfactory solution, with the exception, however, that the bill provides that all requests for funds be first approved by the Budget Commission. This must be construed to include private and publicly endowed institutions as well as those owned and operated by the state and county governments.

Medical College Expansion Program

Our work in connection with this subject is probably already sufficiently known to avoid the necessity of its discussion in much detail here. As, of course, was necessary in order to secure the public and legislative backing and support, full publicity was given to the activities of the Committee of 17 and the subsequently appointed Committee of 46, to both of which committees your Director acted as Secretary, ex officio. All of the meetings of the Committee were attended in Columbia and Charleston, numerous letters written from our office, records of the committee's work compiled, and subsequently during the legislative session we spent several days in Columbia

in active effort around the State House in the interest of the bill which was finally adopted. Needless to say, my duties were a very minor part of the great activity, and effort made to secure the passage of this legislation, but the Committee, under the able leadership of Dr. James McLeod, our President-Elect, accomplished a gigantic task in securing passage of the Act bearing the huge appropriation called for.

Blue Cross Organization

At long last Governor Williams, immediately following the opening of the legislative session in January, signed the Blue Cross measure and it became law. Conferences and one organization meeting were held, but due to the suggestion by the Governor that further amendments be made to the Act, definite effort toward completing the organization were held up temporarily, awaiting developments. Immediately following adjournment of the Legislature, plans were evolved for calling another organization meeting. It was decided to increase the membership from the original number to approximately 36, with the medical profession, the hospital profession and the public at large being equally represented. In this expansion, six doctors were added to the list and their consent to serve was obtained. The meeting referred to was held on Friday, April 26, and we are pleased to report at this time the perfecting of the organization with the following officers elected: Roger S. Huntington, Greenville, President; George A. Buchanan, Columbia, Vice President; John W. Rankin, Superintendent Tuomey Hospital, Sumter, S. C., Secretary; and J. B. Norman, Superintendent Greenville General Hospital, Greenville, Treasurer. The following doctors are included among the 15 members of the Board of Directors: Dr. Julian P. Price, Dr. J. A. Sasser, Dr. Heyward Gibbes, and Dr. Robert Wilson, Jr. With the setting up of this organization our entire work with respect to the Blue Cross Plan and that phase of the Ten Point Program is considered complete. From this point on the matter is in the hands of its officers and Board of Directors. We are closing the file on this subject and no further effort in connection with that phase of the work is contemplated.

Veterans Care Program

Complying with the direction of Council at a recent meeting, we procured an appointment with officials of the Veterans Administration in Washington on April 10th and discussed at length several plans for an agreement between the Administration and the South Carolina Medical Association on a standard fee schedule, and the administration of medical services, in examinations and treatment to outpatient veterans. An outline of the conference in detail, with the several plans suggested and recommendations, is covered by a separate report to Council. The purpose was to obtain all available information and data for action by Council and the House of Delegates. It is presumed that such action will be taken at the session and the facilities of the office and our services will be freely available for any work in connection with whatever program may be adopted. In connection with and before our visit to Washington, copies of the Rhode Island and Kansas plans were obtained and carefully considered and it is evident that there should be no difficulty in arriving at an agreement with the Veterans Administration on a schedule of fees which will be entirely satisfactory to the membership of this Association. It was extremely gratifying to find the Administration in a cooperative frame of mind, with its principal objective the assurance that there will be available to all veterans medical care and treatment for service

connected disability, at fees commensurate with those charged regular patients in the same community.

Basic Science Law

At the request of Dr. Brockman, copies of the Basic Science Law in effect in several of the states were obtained and carefully studied and compared, with the view of developing a proposed bill for recommendation to the legislature for adoption in South Carolina. In view of the numerous other activities with which the Association was involved at that time, however, and other reasons, at Dr. Brockman's suggestion no further effort was made on the subject and the matter was not presented to the legislature at the last session. The file is intact and the matter can be taken up further if and when it appears desirable to do so.

National Health Bill

At its meeting on January 3rd, the House of Delegates appropriated \$1,000.00 for the purpose and directed an active campaign to educate the public as to the provisions and implications of the Wagner-Murray-Dingell Bill pending in Congress. Hearings on this bill commenced April 2nd. Pursuant to this direction, a definite program of meetings and addresses was outlined and a number of the doctors in the state were requested to participate. A list of the communities in South Carolina where it was thought discussions would be most valuable, was made up and a letter addressed to one of the physicians in each of those communities, requesting him to arrange with one or more of the service clubs or other civic organizations to devote a program to discussion of this subject. We then wrote to several doctors known to be qualified as public speakers and asked them to devote the necessary time to prepare and deliver talks on the subject.

A quantity of material was prepared in our office and mailed to each of the doctors who had agreed to speak and to a considerable number of others, including the members of Council and other officers of the association. The material included a summary of the highlights of the pending Bill, a reprint of our analysis of the bill introduced in May 1945, and a quantity of editorial comment and other extracts from various publications.

Thirty-three clubs to date have been addressed by the following:

Dr. W. T. Brockman, Greenville: Kiwanis Club, Spartanburg; Rotary Club, Seneca.

Dr. J. D. Guess, Greenville: Kiwanis Club, Greenwood; Anderson County Medical Society; Rotary Club, Spartanburg.

Dr. L. P. Thackston, Orangeburg: Kiwanis Club, Sumter; American Legion, Beaufort; Kiwanis Club, Charleston; Lions Club, Manning.

Dr. W. A. Black, Beaufort: Kiwanis Club, Beaufort.

Dr. H. S. Gilmore, Nichols: Kiwanis Club, Conway.

Dr. Roderick MacDonald, Rock Hill: Lions Club, Spartanburg.

Dr. G. M. Truhack, Orangeburg: Joint Meeting Lions and Rotary, Walterboro; Coastal Dental Assn., Orangeburg; American Legion, Orangeburg; Lions Club, Orangeburg (To talk to).

Dr. Walter Mead, Florence: Rotary Club, Sumter; Rotary Club, Columbia; Rotary Club, Florence; Rotary Club, Marion (To speak to).

Dr. Howard Stokes, Florence: Kiwanis Club, Bennettsville; Pilot Club, Lake City; Kiwanis Club, Florence.

Dr. James McLeod, Florence: Rotary Club, Bennettsville.

Dr. J. P. Price, Florence: Lions Club, Conway; Rotary Club, Marion (with Dr. Meade).

Dr. C. A. Kinney, Florence: Rotary Club, Lake City.

Mr. M. L. Meadors, Florence: Rotary Club, Conway; Pee Dee Medical Society, Florence; Lions Club, Elleree; Kiwanis Club, Columbia; Florence County Health Council, Florence; Joint meeting arranged by Civitan Club of Mullins, with Lons Club of Mullins and Civitan Club of Nichols.

So far as we know, every request for a meeting was complied with, and according to our information every one went off as planned. The reaction of every group to which we spoke personally was splendid and there was no question whatever of the sentiment of the hearers on the subject. The effort was made to present the discussion as fairly as possible, pointing out the advantages of certain provisions of the bill and at the same time, of course, the serious disadvantages of the greater portion of the measure, which we know to be dangerous. Having had the opportunity to observe the attitudes of a good cross section of the general public throughout South Carolina, in the cities and in the small localities, we are convinced that public opinion in this state is predominantly opposed to the idea expressed and the system contemplated in the Wagner-Murray-Dingell Bill. There is one element of the population which perhaps has not been reached through this means, and that is organized labor. It may be as well, however, since in all probability what might have been said to those groups would have had little effect and they would continue to take their lead from their recognized officials in their organizations.

At several of the meetings, notably Mullins, Marion and the Florence County Health Council, the group voluntarily and without any prompting from the speaker, and without any prearrangement, adopted motions to express their sentiments to our Congressmen and Senators and urge opposition by the lawmakers to the measure. In Mullins the program was concluded with a question and answer period in which the matter was thoroughly discussed and numerous angles of the subject developed by questions from the audience. The interest manifest was encouraging. It was an indication of the awakening of the people of South Carolina to the impending danger and to the responsibility of the public, as voters, in taking an active interest and making a positive effort toward directing the course of events in Washington.

In addition to the foregoing, a statement was prepared, submitted to and approved by Council at a recent meeting, of the position of the Association on the subject and this was given to the press of the state and generally carried. Also, and with Council's approval, space was bought in the State and the News and Courier, and formal advertisements setting out some of the facts and opposing the measure, were published over the name of the South Carolina Medical Association.

During our recent visit to Washington in connection with the Veterans Care Program, we called on

Senator Johnston and were accompanied by him to one of the hearings of the Committee on Education and Labor. Senator Johnston participated in the hearing and in the cross-examination of Mr. Harold Ickes, former Secretary of the Interior, and other witnesses then engaged in presenting testimony in favor of the passage of the bill. At this time we conferred with Dr. Joseph S. Lawrence, Director of the Washington office of the American Medical Association, and the information received from him coincided with that obtained from other sources in Washington, to the effect that the odds are definitely against the passage of the bill at this session. This, we are glad to report, but certainly we cannot afford to relax our efforts because of it. One visit to the hearings was enough to convince us, if we had not already realized the fact, that the proponents of the measure are highly intelligent, well organized, nationwide and determined. A defeat now will only serve to sharpen their efforts and the fight will be promptly renewed.

In conclusion, we desire to express our thanks to Dr. Julian Price, Secretary, for his able advice and suggestions in connection with the work of our office, to Dr. W. Thomas Brockman and Dr. James McLeod for their courtesy and consideration relative to all phases of the work which have been rendered in connection with their respective offices, and Dr. R. B. Durham, Chairman, the members of Council, and the other doctors who participated in the speaking programs and in making the arrangements, for their cooperation in carrying out the public relations policy.

Respectfully submitted,

M. L. Meadors

The Chair: We will hear the report of the Secretary, Dr. Julian Price.

REPORT OF THE SECRETARY

Your Secretary begs to present the following report of the past year's activities.

Membership

Our membership last year was 926. Of these, 139 were in service, and 97 were honorary members. Indications point toward a slight increase in membership for 1946.

Finances

The finances of the Association are in sound condition. The annual audit report has been presented to Council and has been printed in the Journal.

A proposed budget for 1946 was prepared by the Treasurer, and this was adopted by Council. This budget calls for an increase in expenditures in the department of public relations and in the field of public education. This is made possible through the higher annual dues, adopted by this House of Delegates last year, and through increased revenue from the advertising in the Journal.

The Journal

In spite of great difficulty in securing material for publication, the Journal has been published each month. The Editor wishes to express his special thanks to the Editorial Board and particularly to Dr. J. I. Waring for the help rendered in securing scientific papers, and to Mr. M. L. Meadors for his painstaking care in preparing the section entitled "The Ten Point Program."

With a return to our annual scientific meetings

and with more time available for physicians to write papers, it is hoped that from now on the scientific section of the Journal will show both improvement and growth.

The Editorial Board and the Editor want to make the Journal informative, instructive, and interesting. Toward this end we invite suggestions and criticism.

Members in Service

During the past twelve months a large number of our colleagues in military service have been discharged and have returned to their former homes. Words cannot express to these men the pride which we have in them, the gratitude which we owe them, and the joy which we feel upon their return.

Your Secretary has had opportunity to converse and to correspond with many of these men and has endeavored to use his office in every way to be of service to them.

Procurement and Assignment Service

During the past few weeks the South Carolina office of the Procurement and Assignment Service for Physicians has been officially closed.

The amount of work entailed in the management of this office during the past four years was tremendous. For effective handling it required not only energy but tact and honesty on the part of the administrator.

That the South Carolina office of Procurement and Assignment was administered so well that it received commendation from the national office as well as from the physicians of this state, was due to the work and the character of our state chairman, Dr. W. L. Pressley of Due West. To him we proffer the thanks of our Association for a job well done.

District and County Societies

It has been the privilege of your Secretary to visit a number of the district and county societies during the past year and he has noted a marked increase in interest, in attendance, and in fellowship at the meetings. The larger societies are maintaining a high standard of scientific program and the meetings of these societies are well attended by both members and guests. Some of the smaller societies are uniting their forces in the holding of joint monthly meetings and such effort is to be highly commended.

Of particular interest and pleasure to your Secretary has been the desire and willingness on the part of the county societies to participate in the general program of the work of the Association (as evidenced by the efforts of county societies in behalf of the Medical College Expansion Program, the Blue Cross Service Plan, and the fight against a federal system of medical care).

Your Secretary is convinced more strongly than ever that the strength of an Association lies in its integral county medical societies. If the societies are strong and active, the Association will be strong and active.

Public Relations

The Director of Public Relations has made his own report so your Secretary will confine himself to a few general remarks upon this phase of the Association's work.

Our Association was the first to present a compre-

hensive statewide program to the public for improving medical care. It was also the first state association to establish a department of public relations with a full time director. That we are in keeping with the times is evidenced by the number of other state organizations which are pursuing a similar course. Only recently, the newly appointed Director of Public Relations from another southern state spent a day in our Association's executive offices studying our plans and methods.

Our work in the field of Public Relations is developing along three lines; that of acquainting the public with the program of our Association for improving medical care in the state, that of conferring and cooperating with other groups and individuals who are working along lines similar to ours, and that of making known to the public the position which our Association takes with regard to medical affairs on a state and national level.

That we have made progress has been due in large part to the work of our Director and to the aggressive leadership of our President, our President-Elect and our Council. But much credit must be given to our individual members whose encouragement has made the task easier and whose money has made the effort possible.

But the progress we have made is far from enough. There is still much for us to do in the field of Public Relations.

Medical College Expansion

The course which our Association followed with regard to the proposed plan for expansion of the facilities of our Medical College is one which any association might adopt as a model course of procedure.

A survey of the proposed expansion was made by the Dean of the Medical College and his advisory committee, and was presented to the House of Delegates for consideration. The House of Delegates instructed Council to appoint a special committee of Seventeen (one representative from each of the state judicial circuits along with the President, Secretary, and Director of Public Relations) to study the survey and to make a report. Under the aggressive leadership of its chairman, Dr. James McLeod, the committee made investigations, held hearings, heard reports, discussed the question under consideration with physicians throughout the state, and submitted its report to a special meeting of the House of Delegates.

The report, which called for an enthusiastic endorsement of the plan proposed by Dean Lynch and his advisory group, was adopted unanimously by the House of Delegates. With this wholehearted endorsement of the Medical Association, the plan was submitted to the General Assembly.

When the plan came up for consideration before the state legislators, arrangements were made for the Chairman of the Committee of Seventeen to speak in its behalf before a joint assembly of the Senate and House of Representatives. For the first time in South Carolina history, a representative of the South Carolina Medical Association addressed the entire membership of the General Assembly.

As a result of Dr. McLeod's clear and forceful presentation, backed as it was by the careful study of the Committee of Seventeen and the unanimous endorsement of the House of Delegates, the plan was translated into law. And in the not too distant future the Medical College of the State of South

Carolina should boast of a physical plant which any state would view with pride.

The medical profession of South Carolina today and the young doctors of tomorrow owe the Dean and his advisory committee, the Committee of Seventeen, the House of Delegates, and Dr. James McLeod, a great debt of gratitude for what has been accomplished.

Hospital Survey

Rejecting the proposals advanced by the House of Delegates and the Council, the General Assembly designated the State Planning Commission as the agency to make a careful study of hospitals in the state as regards present facilities and future needs. An advisory committee of eleven was provided for, however, and three of these are to be physicians, recommended by Council and appointed by the Governor.

Hospital Service Plan

Finally, after the General Assembly had convened this past January, Governor Williams signed the so-called Blue Cross Bill. We have yet to understand his delay in affixing his signature to this piece of legislation.

Plans are now under way for establishing a statewide hospital service plan and we predict that such a plan will be in full operation by early fall.

Medical Service Plan

Second only to our need for a statewide hospital service plan is our need for a medical service plan, if we are to help the people of this state to secure the medical care which they need at a price they can afford to pay. It is the earnest hope of your Secretary that this House of Delegates will today lay the groundwork for an early inauguration of such a service.

National Medical Organizations

The South Carolina Medical Association is beginning to make itself heard on the national stage of medical affairs and to assume a small but important role in the shaping of national policies.

Dr. Hugh Smith represented us ably in the American Medical Association House of Delegates. Dr. James McLeod and Mr. M. L. Meadors participated actively in a special Conference on Public Relations in Chicago. Mr. Meadors and your Secretary were on the program of a special conference on Medical Service Plans held in Chicago just prior to the meeting of the A.M.A. House of Delegates. Dr. Hugh Smith, Dr. Warren White, Mr. Meadors and your Secretary attended and became charter members of the newly formed Conference of Presidents and other State Association officers. Mr. Meadors represented us at the annual Conference of State Association Secretaries and Editors and Dr. Gordon Spivey, Chairman of exhibits for our Association, was our representative at a special meeting of Commercial Exhibitors in Chicago. At the request of our President, Dr. James McLeod and your Secretary attended a special meeting in St. Louis, held under the auspices of the National Physicians Committee, for the purpose of studying the Wagner-Murray-Dingell Bill and other pending allied legislation in Washington. Our President, Dr. W. T. Broekman, advanced the idea of a national Basic Science Law at the annual meeting of the Tri-State Medical Association in Richmond. And lastly, Dr. W. L.

Pressley and Dr. A. W. Browning have recently served as our representatives at a National Conference on Rural Health.

Each of these men, in his own way, made a contribution to medicine on the national level—a contribution of which our Association can be justly proud.

Looking Ahead

Lying ahead of us are tasks to be done. Our Ten Point Program, which we courageously adopted, must be pushed with all our strength. We have already made a start in the fields of Medical Education, Public Relations, Education of the Public, and Establishment of a statewide Hospital Service Plan. But there is still much to be done along each of these lines. The question of establishing a Medical Service Plan and the problem of better medical care for our indigent await our attention. We must throw our support behind those who are making a hospital survey of the state and see to it that it is comprehensive and accurate and that the expansion of hospital facilities shall be developed in terms of the needs of the people and not in terms of political expediency.

And still facing us is the threat of political administration and control of medicine. The forces behind the plan for a federal system of medical care are strong and everlastingly tenacious and though they may receive a setback this year, they will return. If we are to protect our people and our profession from bureaucratic control, we must continue our fight with unmitigated vigor.

The Centennial

In two years, our Association will be one hundred years of age. It is not too early to begin to plan for the celebration of that occasion. Your Secretary, therefore, presents the following recommendations:

That the Council of the Association appoint a Committee on the Centennial whose duty it shall be to make plans for appropriate celebration of our one hundredth birthday at the annual meeting of the Association in 1948, and whose duty it shall also be to prepare and publish a history of our Association for presentation upon that occasion.

Conclusion

In conclusion your Secretary wishes to thank the President, Dr. Thomas Broekman, the President-Elect, Dr. James McLeod, the Chairman of Council, Dr. R. B. Durham, the members of Council, the Director of Public Relations, Mr. M. L. Meadors, the State Health Officer, Dr. Ben Wyman, the various county society secretaries, and the many members of the Association who have given so freely of their advice and help in the past year's work.

Julian P. Price,
Secretary.

Dr. Price: A telegram has just been received from the South Carolina Dental Association. Dr. R. B. Durham, Chairman of Council, recently approached the proper authorities in the Dental profession with the suggestion that they take some strong action in regard to the Wagner-Murray-Dingell Bill pending in Congress. This telegram reads as follows:

Columbia, S. C.
12:10 P. M.
April 30, 1946

Doctor Mordecai Nachman
Ocean Forest Hotel
Myrtle Beach, S. C.

Get copy today Columbia Record resolution passed

as suggested telegram to all representatives bearing signature three hundred dentists dispatched. Best wishes for pleasant meeting.

John Douglas.

(At the request of the President, Dr. Dibble, Vice-President, took over the Chair.)

Dr. Dibble (presiding): The House of Delegates thanks Dr. Price for this splendid report. We will now have the report of Dr. R. B. Durham, Chairman of Council.

Dr. Durham: Dr. Spivey has put out a lot of work on the exhibits this year and he will be able to turn over to the Association right around \$2,000 profit, which I think is very commendable—and by the way we need it.

REPORT OF COUNCIL

R. B. Durham, Chairman

As Chairman of Council, it is my privilege to present a report of the activities of your Council since the last meeting of the House of Delegates.

Your Council has studied the annual financial report and audit and finds that the Association is in sound financial condition. A budget has been adopted for the coming year which calls for a continuation of the work which we have been doing along with increased activities in the department of public relations.

Your Council wishes to commend Mr. Jack Meadors, Director of Public Relations and Counsel, for the splendid program which he has fostered during the past three months in educating the public concerning pending federal legislation in Washington. Council feels that citizens of South Carolina are beginning to realize that any system of Federal Medicine would be inimical to their best interests.

Your Council wishes to commend Dr. Gordon Spivey, Chairman of Exhibits, for the fine way in which he has handled the commercial exhibits for this annual meeting and for the financial return which has come to the Association as the result of his work.

Your Council was called into special session on January 24, 1946 to consider a situation which had developed in the General Assembly with regard to the proposed Hospital Survey for South Carolina. After a discussion of the problem with a special committee from the South Carolina Hospital Association, your Council went into executive session and after a lengthy and thorough debate, adopted the following resolutions:

"In view of recent developments in the General Assembly which have made it apparent that any plan to place the hospital survey for South Carolina under the direction of the State Board of Health would not be acceptable to the legislators, and believing that cooperation with the State Hospital Association in its effort to secure a hospital survey through the creation of a special commission would be preferable to any other plan, and, believing that it is the function of Council to carry out the wishes of the members of the Association between meetings of the House of Delegates, even though it may entail a change in a recommendation made by the House of Delegates,

BE IT RESOLVED, that Council endorse the creation of a Special Hospital Commission to be

composed of five representatives of this State Medical Association, four from the State Hospital Association, one dentist, one pharmacist, one nurse, the State Health Officer, and four members at large to be appointed by the Governor.

BE IT FURTHER RESOLVED that the President, the President-Elect, and the Chairman of Council be instructed to meet with the special committee of the Hospital Association relative to this resolution and to be empowered to make such minor changes as may be necessary so as to give the resolution the joint support of the Medical and Hospital Associations."

Your Council met again in special session on March 3, 1946. Following an explanation of the hotel situation in Greenville by Dr. M. Nachman, President of the Greenville County Medical Society, it was moved by Dr. Thomas Brockman and passed unanimously that the annual session of the Association be held at Myrtle Beach instead of at Greenville as originally planned.

Your Council also prepared a statement relative to the Wagner-Murray-Dingell Bill which was given to the press for publication. This release appeared in the leading newspapers of the state. Council instructed Dr. J. P. Price, Secretary, to go to Washington as the spokesman for the Association at the hearing of the Wagner-Murray-Dingell Bill, if such arrangements could be made. Efforts to have such a spokesman at the hearings were made but to no avail since appearances were limited to representatives of national organizations only.

Your Council instructed the Secretary and the Director of Public Relations to work out a tentative agreement with the Veteran's Administration for the care of veterans by physicians in civilian practice. Mr. Meadors went to Washington for conference with officials of the Veteran's Administration. His findings along with recommendations were submitted to the President and to the Chairman of Council.

Your Council also heard representatives of the Greenville County Society, Drs. M. Nachman and Chas. Wyatt, who presented the plan for the care of veterans as evolved by the Greenville Society, the Greenville Benefit Hospital Association, and the Veterans Administration.

After careful consideration, your Council recommends to this House of Delegates that it approve the plan of the Greenville County Medical Society for statewide usage.

Your Council appointed a special committee on Medical Care of Veterans with Dr. Chas. Wyatt of Greenville as Chairman. The other members of the committee are:

Dr. M. Nachman, Greenville; Dr. O. B. Mayer, Columbia; Dr. Howard Stokes, Florence; Dr. John Buchanan, Winnsboro; Dr. H. C. Robinson, Charleston.

Your Council is instructed, under legislation recently passed by the Legislature, to appoint three members to the State Advisory Council to the Research, Planning, and Development Board, to advise and assist in a statewide hospital survey. Your Council has appointed the following: Dr. Jack Parker, Chairman of the Committee on Hospital Care; Dr. K. M. Lynch, Dean of the Medical College, and Dr. Julian Price, Secretary of the Association.

In view of the coming centennial of our Association in 1948, your Council has appointed a special committee on the Centennial, Dr. J. I. Waring, Chairman, to make preliminary plans for this celebration and to prepare a history of the Association for presentation upon this occasion.

Since Charleston was the birthplace of our Association, it seems to your Council that it would be fitting that the one hundredth birthday of our Association be celebrated in that city. Your Council would recommend, therefore, that the annual session in 1948 be held in Charleston, provided this is agreeable with the Charleston County Medical Society.

In conclusion, your Council wishes to express its deep and sincere appreciation to Dr. W. T. Brockman, President, and to Dr. James McLeod, President-Elect, for the splendid leadership which they have afforded our Association during the past year.

(The following remarks were made during Dr. Durham's report.)

You have all possibly seen the pamphlet gotten out by Dr. Wyatt of the Greenville Delegation, and I want to compliment them on a very nice piece of work.

The other person I want to thank personally, because he has been a great deal of assistance to me, he even accused me of having to write my own report, is Dr. Julian Price, because he has helped me a wonderful lot in this work.

(Dr. Brockman resumes the Chair.)

Dr. Brockman: I believe the proper procedure is to take up these recommendations of Council in order, is that right? Before we take up the recommendations, the Chair at this time appoints the following Committee on Resolutions:

Dr. Frank Cain, Chairman; Dr. W. W. Boyd, Dr. A. W. Brown, Dr. Hugh Wyman, Dr. Jim Young.

Dr. Price, we will now take up the Recommendations of Council.

Dr. Price: (Reading) "Your Council recommends to this House of Delegates that it approve the plan of the Greenville County Medical Society for statewide care of veterans."

Dr. Jim Young: I move the adoption of that resolution.

The Chair: You have heard the motion. Is there any discussion?

Dr. Nachman: Mr. President, I think most of the members are familiar with this plan. If you want us to, we will tell them about it. Dr. Wyatt, chairman of the committee, went to Washington and made arrangements whereby we could take care of the veterans at home. The Veterans Administration wanted a single agency to act as their agent, whereby this agency would pay the doctor bills as they are presented to them and then they would send the bill on to get their money with a certain percent for handling charges. The doctor who was to take care of the veteran would write the South Carolina Hospital Benefit association and register with them so that they would be on the list. Now, for your information this Hospital Benefit Association in Greenville was organized in 1938. It is under the Duke Endowment and it has a surplus capital of \$35,000 to handle this claim. The Veterans Administration and Council

thought this was the agency and was willing to accept it. I would like now to let Dr. Wyatt tell you just what the real program is.

Dr. Charles Wyatt: Gentlemen, in presenting this plan we had drawn up the program in a fee schedule and we have got as high a fee schedule as you could possibly get throughout the United States. The fee schedule was adopted by the Veterans Administration without question. We thought it best to set the high rate and reduce, if we had to, than set it low and try to raise it. The Veterans Administration adopted the fee schedule and we have it in effect and hope to have this program in Greenville by the 1st of May.

The contract we submitted to the Veterans' Bureau was not acceptable. In a few particulars they rewrote the contract, the major portion of which dealt with discrimination between race and creed, which changes were accepted. We accepted that for after all we will take care of the colored folks. This contract is signed by the Hospital Benefit Association of South Carolina who is acting as our agent and the contract is in Washington for acceptance. Since they wrote the contract and mailed it to us for signature there should be no trouble there.

We feel this is one stick, this is one wedge that we can throw into Washington to more or less put a clamp on any socialization of medicine throughout the United States. They have offered us this means of taking care of veterans and we are about the 7th or 8th State in the Union to submit a plan to them. If you adopt it, I mean. Those states who have submitted a plan and have been accepted, up until a few days ago, were only about six—Kansas, Michigan, New Jersey were the first three, and since then California and our neighbor state of North Carolina—and the day we were in Washington Ohio had a delegation there talking the matter over with the Veterans' Administration.

Gentlemen, I think it is one means that we have of starting something in South Carolina that will put us up towards the top of trying to combat, by some active method other than talk, socialization.

If you stop to realize it, there are about 12 to 13 million service people who desire to be taken care of as much as possible in their own communities by their own physicians and at their own hospitals. It is definitely something that we can use and use effectively in combatting any means of socialization insofar as medical practice is concerned.

We offer you this plan, we don't offer you a plan as accepted definitely, because we haven't got it signed, sealed and delivered, as yet, but we have the plan and contract submitted to us by the Veterans Administration. It has been signed in our own local community of Greenville and we feel that since they have submitted it that they will sign it.

We would like to see the State of South Carolina adopt this plan. We would like to see the State of South Carolina put it into effect. We feel it is worth it. We feel we have the machinery which we can put into effect immediately and we feel you can work it out effectively to the benefit of all concerned.

The Chair: Thank you, Doctors Nachman and Wyatt. Is there any discussion?

Dr. Jim Young: I would like to ask a question. The speakers have mentioned the fact this proposed service to Veterans is for service connected maladies.

I notice the schedule provides for delivery service, obstetrical service. I can't see how they could be service connected.

Dr. Wyatt: The Veterans' Administration provides medical service for all female employees insofar as they were connected in service, that is WACS, SPARS and WAVES, they are entitled to service whether or not they are service connected disabilities, if they are authorized by the Veterans' Administration.

The Chair: Does that answer your question, Dr. Young?

Dr. Young: Yes, sir.

The Chair: Is there any further discussion, or questions? We want you boys to be thoroughly familiar with this thing before you vote.

Are you ready for the question? All in favor of the South Carolina Medical Association adopting this plan, this veterans' Hospital agreement, will please say "aye." (The vote was unanimous for the adoption.) It is so ordered. The next recommendation.

Dr. Price: Your Council would recommend that the annual session in 1948 be held in Charleston, provided this is agreeable with the Charleston County Medical Society.

Dr. Lynch: I move its adoption.

Dr. Nachman: I second the motion.

Dr. Robert Wilson, Jr.: On behalf of the Charleston County Medical Society, the mother society of this Association, I invite you to Charleston. According to my information this Association was formed in Charleston in 1848 at a meeting held on the invitation of the Charleston Medical Society. We want you to come to Charleston in 1948, we want you every year but particularly in 1948 when we will celebrate the first meeting of this Association. Dr. James Moultrie was elected president and the President of our Medical Society sits in the same chair given by Dr. Moultrie. The Medical Society of Charleston cordially invites the South Carolina State Medical Association to meet in Charleston in 1948.

(Applause)

The Chair: You have heard the invitation—you have heard the motion which was seconded that we go to Charleston in 1948. All in favor signify by saying "aye." (The vote was unanimous.) It is so ordered.

The Chair will recognize Mr. Wheeler of the World Insurance Company.

(Mr. Wheeler, representative of the World Insurance Company, spoke to the House of Delegates regarding a comprehensive plan of group insurance. He explained that his company was 43 years old, one of the oldest and one of the largest companies according to Gunn's report, that it operated in the State of South Carolina under the Insurance Department and was bonded. Mr. Wheeler described the type of policy, its premiums, disability benefits and other provisions. He thanked the House of Delegates for the privilege of appearing before them.)

The Chair: If there is no objection, the Chair feels this new Resolution Committee ought to get to work and call on the Public Relations attorney to advise them and talk this insurance plan over and come back and report to us. If there is no objection,

the Chair will do that now. Thank you, Mr. Wheeler.

Dr. Cain (Chairman of Resolutions Committee): Mr. President, you appointed me chairman of this committee, I didn't realize any resolution was to be had. I understood that this was brought to us for information and that you desired us to think about it. But, if you desire us to go outside and bring in a recommendation we will do it.

The Chair: That is what we want. Dr. Cain. (The Resolutions Committee, accompanied by Mr. Meadors, Public Relations Attorney, retire.)

We will now hear the Report of the State Board of Health, (Dr. W. R. Wallace, Chairman, Executive Committee.)

REPORT OF EXECUTIVE COMMITTEE OF STATE BOARD OF HEALTH

Mr. President and Members of South Carolina Medical Association:

The clouds of war have lifted. Many of the valued members of the personnel of the Health Department have already returned to their former positions. Seventy-eight employees of the State Board of Health served their country with honor and distinction in World War II. We honor them for their patriotic service knowing full well that the magnificent record both as to morbidity and mortality in this war was due to the efficiency of all branches of medicine.

We wish also to commend those who remained on duty on the home front, many of whom took on added duties. We passed through the war period without any major epidemic of any kind, notwithstanding the fact that we had more soldiers and visitors in our state than ever before in its history. The vigilance of our health and sanitary officers contributed largely to this fortunate state of affairs.

We regret that Dr. R. W. Ball, who served so efficiently in the Maternal and Child Health Department before going into the service, has resigned to take up the private practice of pediatrics. He did a splendid work in this important division. Dr. Hilla Sheriff who directed this department during Dr. Ball's absence has been selected to direct this program.

Dr. C. L. Guyton has taken up again his duties as Director of Cancer Control and in addition will direct the Division of Venereal Diseases.

Dr. Harry F. Wilson has also returned to active duty as Director in Industrial Health. We regret to report that Dr. Zerbst who substituted during Dr. Wilson's absence is seriously ill.

At the recent session of legislature sufficient funds were appropriated to continue the broad program of preventive medicine that the medical profession has been sponsoring for some time.

In addition to the state appropriation we are glad to report that a fund has been approved of \$300,000 for the tuberculosis and \$200,000 for a hospital to be used in the rapid treatment for venereal diseases. A considerable portion of the money for the state hospital will be used to increase the facilities for treating colored patients, an item in tuberculosis control which has been inadequately provided for.

The campaign against venereal diseases, the rapid treatment of syphilis in particular, seems to be showing results. There is a very definite decrease in syphilis in South Carolina. We hope that the time will come when the hospital for treatment of venereal diseases may be converted into a home for incurable cancer or perhaps used for some other purpose.

In the last report we stated that we hoped to take over the examination of water in the laboratories of the Health Department at the central office in Columbia. For some reason legislature did not see fit to pass the necessary legislation to make this possible. So water examination will continue to be made in private laboratories as it has been done for many years by the Parker Laboratories under the capable direction of our lamented and esteemed Dr. Frank L. Parker of Charleston.

The Hospital Survey Bill, which had some public health angles and which was pending since last year, was placed under the Research, Planning and Development Board and was passed at this session of the General Assembly. We hope this matter has been settled to the satisfaction of all so that we will be prepared to participate in federal funds when they become available.

South Carolina is making rapid progress in milk and dairy production and to some extent in meat production also. The State Health Department is continually making available information on the proper handling of these commodities and adding rules and regulations to safeguard the health of the people. More pasteurized milk should be available in this state. The great increase in freezer-locker plants will introduce another health hazard if proper regulations are not made and enforced.

At this time all departments of the State Board of Health are functioning well and we believe that preventive medicine in South Carolina is on the eve of the greatest development in its history. There has been a steady downward trend in the mortality rates in all of the preventable diseases. May I call your attention to just a few figures to illustrate this fact. In 1920 there were 1337 deaths from tuberculosis with a rate of 88.2 per 100,000 population and in 1945 there were 693 deaths with a rate of 35.2. In 1920 there were 97 deaths from diphtheria with a rate of 6.4 and in 1945 there were 30 deaths with a rate of 1.5. In 1920 there were 262 deaths from typhoid with a rate of 17.3 and in 1945 there were 42 deaths with the rate of 2.1. In 1920 there were 414 maternal deaths with the rate of 10.9 and in 1945 there were 190 deaths with a rate of 3.7. In 1920 there were 4556 infant deaths with the rate of 119.5 and in 1945 there were 2694 deaths with the rate of 52.1. Smallpox has almost become a nonentity.

Your Executive Committee solicits your continued interest, support, and constructive criticism. We believe progress in preventive medicine in South Carolina will compare favorably with that of any other state. We are leaders in some public health endeavors. Why should we not be leaders in many more?

W. R. Wallace, M.D., Chairman

The Chair: I see the Resolutions Committee is ready to report, Dr. Cain.

Dr. Cain: The Committee on Resolutions feels that this association certainly could not take any action on this insurance proposition today, so the committee recommends further that Council study

this proposal in connection with our counsel—and he, together with Council bring in a recommendation to the Association at a future date.

The Chair: You have heard the recommendation of the Committee on Resolutions. Are you ready to vote? (It was moved and seconded that the recommendation of the Resolutions Committee be adopted. This motion was voted on and passed unanimously.)

The Chair: Thank you, Dr. Cain and your Committee. Now, we will have the "Report of Delegate to Rural Health Conference"—Dr. W. L. Pressley.

(Dr. Pressley made the following remarks before he made his report on the Rural Health Conference.)

In the relocation of physicians we have tried to take care of the emergency. The Chairman of the State Board of Medical Examiners and his Board have been most helpful and have exerted every effort and we have in practice in the State now two graduates of "B" schools, and I have notified them their term of service is over. I want to thank these two boys, these doctors who have helped us out. They are popular in the communities they served and they filled a need that we couldn't have served in any other way.

Mr. Meadors and this Committee of Relocation of Doctors met in Columbia and we spent a couple of hours picking men to make a quick survey of the counties, with the request that they write us their needs. Only 15 of the representatives selected responded. Their replies were forwarded to me and each need was followed up and I take it there is no emergency in any county which we did not help. Today we have very few localities or small towns not adequately supplied with physicians.

I don't know how it has been worked out but we have had some very happy experiences in locating men in towns during the war time and they have made fine records. The towns have assisted in getting offices fixed and in one instance they furnished a home. We feel the service is well worth while.

Just yesterday I got a letter from the Mayor at Swansea. They lost a physician and we are putting them in connection with Captain Guess, located in Alabama. He wants rural practice and they will probably get together. The Town of Branchville has been a nightmare. We have sent people there but haven't been able to work that out but are hopeful it will be taken care of in the near future.

As far as relocation of physicians—officially the Procurement and Assignment is closed but we have the data and will always be glad for you to drop by the office and we will give you the facts we have and will try to help all we can in the location of our men.

REPORT ON RURAL HEALTH CONFERENCE

At the request of the Council of the South Carolina Medical Society Dr. A. W. Browning of Elloree and I represented South Carolina at the First National Conference on Rural Health. This meeting was planned by the Committee on Rural Medical Service of the A.M.A. Dr. F. S. Crockett of Lafayette, Indiana is chairman of this committee. Each state was requested to send two delegates to this meeting.

The meeting was called to order by the chairman at 9:30 A.M., March 30, 1946 with about 300 in attendance. Various groups interested in Rural Health were represented, namely: American Farm Bureau Federation, Public Health Service of the

Farm Security Administration, Council on Medical Education of the A.M.A., Health Advisory Council of the Chamber of Commerce of the United States, Farm Foundation, Associate Women of America Farm Bureau Federation.

It was the opinion of Dr. Browning and myself that the outstanding talk of the morning session was made by Mr. Ransom E. Aldrich, Chairman of the Medical Care Committee of the American Farm Bureau Federation. Mr. Aldrich presented many facts as to rural medical service in general and especially pertaining to the state of Mississippi. He stressed a subject concerning which Dr. Browning and I had talked the night before the meeting—that is the dangers of numerous small hospitals in every county and the inability to operate these hospitals both from an economic and staff standpoint. He very much favors the small medical centers with direct connection with a central hospital operated by several counties. This seems logical to your committee. He also stressed the cost of medical care in many rural districts in his own state of Mississippi. In several of the more isolated counties without a local physician the average cost was one dollar per mile plus three dollars making a total of from twenty to twenty-five dollars per visit. He seems to think this scale of charges was established on the time consumed to make a visit before the era of good roads and automobiles. Surely not many of our rural families can finance illnesses on this scale of charges. I do not believe it obtains in South Carolina. I had hoped to enclose a reprint of his address but it was not available.

Most interesting also was the address of Dr. Leland Tate, Ph.D., of the Farm Foundation. He dwelt at length with the psychology of the farmer and presented many facts to support his analysis of the farmer and farm life. He pictured the American farmer as a very independent individual not asking or seeking aid for his medical care but very anxious that he be able to secure the best in medical services for himself and family. He was a very attractive speaker and most logical in his reasoning. I must admit that he was shooting a little over my head and from the expression on Dr. Browning's face I believe he was having the same trouble. The one thing that impressed me most in his address was the enormous amount of thought and study that he had given this subject.

The luncheon address was delivered by the Honorable J. Percy Priest, Congressman from the Sixth District of Tennessee. Mr. Priest is chairman of the committee on rural health measures in the United States Congress. He states positively that the Hill-Burton Bill will be passed. All groups represented seemed to agree with the Hill-Burton Bill in principle; however, it was emphasized that the rural medical care was a responsibility of the State and County Government, to be administered at a state and county level. It was rather surprising and gratifying at the very positive stand against too much interference by the Federal Government and government agencies. Mr. Priest prefaced his address by the usual line of being born on a farm in a log cabin. However, he knows how to protect himself as to commitments. I can truthfully say that I have never listened to nine more interesting and instructive addresses than those delivered at the morning session.

The afternoon session was confined to talks limited to five minutes by representatives from each state. Most of the states were represented; however, our sister states of North Carolina, Georgia and Florida were not. The chairman called on each state alpha-

betically to give a report on the progress made in this phase of medical care. Dr. Browning reported for our state and gave a most interesting account of the activities of our State Medical Society and the State Board of Health. It was indeed gratifying to learn that our society seems to be as wide awake or indeed more progressive than most of the states represented. I was rather surprised to hear the adverse report on the medical service of the FSA in most of the states. Personally my feeling is that this service has been well worthwhile. Probably not in large remuneration for services rendered but in the satisfaction of knowing that we have extended a helping hand in this most worthy undertaking. We must never lose sight of the fact that ours is a life of sacrifice, to give help to those who are less fortunate than ourselves. I do not know that the South Carolina Medical Society will agree with me but I am 100% for the activities of the FSA.

President-Elect of the A.M.A., Dr. Harrison Shoulders of Nashville, attended the afternoon session and addressed the meeting. As we all know, Dr. Shoulders is a grand person and highly esteemed by the medical profession and is most unusually qualified for the position he now holds. Surely the South is greatly honored in having him as President-Elect of the A.M.A.

Also present at the meeting was Col. George Lull who has recently joined the A.M.A. Staff as general manager. He wished to be remembered to his many friends in South Carolina. Doubtless you know that Col. Lull was Deputy Surgeon General during the recent world war. He was the civilian doctor's friend and could always see matters from the standpoint of the civilian doctor.

Impressions

1. The tremendous amount of interest shown in the problem of rural health.
2. The determination of all the groups interested in rural health to see that adequate medical care is received.
3. The desire that this service be rendered by the medical profession without too much interference by governmental agencies.
4. The desire that this service be rendered on a state and county level.
5. The unanimous opinion that the Hill-Burton Bill most nearly fits into this pattern.

Recommendations

What should the State Committee on Rural Medical Service undertake?

Meet with interested farm groups—Farm Bureau—Grange—Farmers Union and agree on objectives for common effort.

Three general types of activity may be considered:

1. Hill-Burton bill. See that sound judgment is exercised in placing of facilities and other details applying to rural areas. (a) Insistence on and devising methods for maintenance of high professional standards in all facilities constructed so that more service will not mean service of lower quality. (b) Deciding what constitutes the unit to be served by various types of facilities, number of people, distance the sick can be transported, desirability of a public ambulance service. The present available professional personnel and possibility of attracting more. (c) Deciding what is meant by diagnostic center-health center and their relation to the hospital as they should apply in each state. (d) Close affiliation with agencies of state government created to administer the Hill-Burton bill or like legislation.

2. Extending to country people the benefits of prepayment plans for catastrophic illness and hospitalization.

Special plans for marginal farmers who may be in part medically indigent, but should be encouraged to pull their pound.

3. Promotion of health education among farm people. Initiative here must reside in organized farm groups: Parent-Teachers—4H Clubs—Home Economics Clubs—Boys camps—Extension departments of State Agricultural Schools—Accident prevention and first aid—sponsoring proper kind of publicity in farm press—local papers and local radio.

4. Conference of Rural and Health leaders sponsored by State Colleges of Agriculture, Ohio University is a good example.

(Dr. Pressley reported the Procurement and Assignment Service officially closed and thanked the Association for their support, etc.)

On March 31 the Procurement and Assignment Service of South Carolina for Physicians came to an official close. May I take this means of thanking you for the privilege of having a part in this service. For the past five years, with the help and advice of the officers and Council of the Association, I have endeavored to the best of my ability to discharge the duties which this service imposed. I have no doubt but that mistakes were made. This is true of every human endeavor. Nevertheless, I do claim that this organization has been run on an honest basis. It has been our constant endeavor to determine each case according to its merits. No case, to my knowledge, has been handled or allowed to be influenced by politics or local jealousies.

I deeply appreciate the fine spirit of loyalty and devotion manifested by the doctors who were selected to serve in the armed forces. Just as truly do we recognize the tremendous service rendered by those who remained to carry on the ever increasing duties at home.

I feel very deeply, and want to say so, that the benefits I received from happy associations with our doctors have far outweighed the inconveniences and extra hours of work connected with the duties of this office.

The South Carolina Medical Association has certainly been most kind to me. You have given me the privilege of serving in various capacities. I can truthfully say that I have greatly enjoyed and been helped by every service I have been able to render. It is now my wish, not to retire, but to return to the Infantry and carry on as best I may for the good of the doctors of South Carolina, a wonderfully fine bunch of fellows.

With sincere appreciation and thanks.

The Chair: We will now have the Report of State Board of Medical Examiners—Dr. N. B. Heyward, Secretary.

Dr. N. B. Heyward:

This year we have already had to revoke one license and we have two more that I am afraid will have to be revoked. In regard to Grade "B" men in South Carolina, there are a number of them here that have helped us out a great deal. They are anxious to be admitted. It is the policy of the State Board of Medical Examiners not to admit Grade "B" physicians by reciprocity or by examination.

April 30th, 1946.

House of Delegates
S. C. Medical Assn.
Myrtle Beach, S. C.
Gentlemen:

Hereby is submitted for the yearly report for the Journal the number and class of applicants for license to practice medicine and surgery in South Carolina for the year 1945.

Date	Examination		Reciprocity	Totals
	Passed	Failed		
June 25-28	56	0		56
Nov. 13-15	2	0		2
During 1945			29	29
Totals	58	0	29	87
Licenses Revoked				1

Respectfully submitted:

N. B. Heyward, M.D., Sec.

Dr. Julian Price is recognized by the Chair.

Dr. Price: Dr. James McLeod, Chairman of the Committee on Medical Education, asked me to report that since the Medical College Expansion Program is well covered in the report of the Director of Public Relations and in the report of the Secretary, he has no report to make.

The Chair: The Report of Permanent Committee on Hospitals, Dr. Jack Parker, Chairman.

The report of the activities of the permanent committee on hospitals, for the sake of brevity and prevention of repetition, begins with the resolution passed by the last meeting of the House of Delegates, January 3, 1946, at Columbia. This resolution was as follows:

"Resolved, that this House of Delegates disapprove of the plan to have a hospital survey made by the State Planning Commission and the plan to sponsor a new commission, and that this House of Delegates approve of the plan which calls for a hospital survey to be made by the State Board of Health with the help of an advisory committee and,

"Be it further resolved, that this House of Delegates endorse the bill now in the General Assembly which would provide for such a survey to be made by the State Board of Health."

Following this, members of the committee met in Columbia, January 17, with the executive committee of the South Carolina Hospital Association, which association definitely opposed and was actively working against the passage of such legislation in the House of Representatives. It was the feeling of your committee that this opposition could be stemmed and the State Board of Health be named as the state agency, provided an advisory commission, with some definite power, also be set up to work with the Board of Health. However, after meeting with members of the Medical Affairs Committee of the House and other legislators that were felt to be friendly to passage of legislation requested by the medical profession of the state, a conclusion was reached that this could not be accomplished.

The President of our Association, Dr. Brockman, who was present at these various meetings, felt that, since it appeared impossible to have the resolution of the House of Delegates passed, a meeting of council should be called. This called meeting met in Columbia, January 24, and, after due consideration, instructed our committee to support a bill to create a state agency for the hospital survey and construction program that should be composed of five members from the State Medical Association, five members from the State Hospital Association, one member

each from the State Dental Association, the State Pharmaceutical Association and the State Nurses' Association; also, the State Health Officer, and three users of hospital service to be selected by the Governor, none of these latter three to be a member of or affiliated with any of the above named organizations.

Following this, to prevent a divided opinion before the legislators, another meeting was held with the Executive Committee of the South Carolina State Hospital Association, who agreed to support this plan. When the proposed legislation was not concurred in by the Senate and House, it automatically went to free conference and the law as finally passed is essentially this:

The Research, Planning and Development Board is really the state agent, and the duties shall be as follows: (a) Make surveys of the location, size and character of all existing public and private (proprietary as well as non-profit) hospitals, health centers, and other related facilities in the State; (b) evaluate the sufficiency of such hospitals, health centers, and related facilities for furnishing adequate hospital, clinic, and related services to all the people of the State; and (c) compile such data and conclusions, together with a statement of new or expanded facilities necessary, in conjunction with existing structures to supply such services.

Serving as a State Advisory Council, to advise and consult with the Research, Planning and Development Board, the following Council is to be appointed by the Governor: Three from the membership of the State Hospital Association to be nominated by its Board of Trustees, three from the membership of the South Carolina Medical Association, to be nominated by its Council; one from the membership of each of the following: The State Dental Association, and the State Nursing Association, to be nominated by the heads of the governing bodies of said associations, respectively; the State Health Officer, and two citizens familiar with the need of hospital service in rural or urban areas, to be selected by the Governor, none of whom shall be a member of or affiliated with any of the above-named medical or related medical organizations.

The general program covering standards of survey, evaluation of need and the statistics to be gathered by the Research, Planning and Development Board shall be first approved by the Advisory Council.

The act also provides that the Research, Planning and Development Board is designated as the sole state agency to apply to the Federal Government for financial and other aid and to accept and receive any Federal funds, grants or advances that may be obtained, and to deposit the said funds in the State Treasury, and to disburse upon warrants of the Comptroller General, with the approval of the Director, provided, however, all applications for Federal aid must first be approved by the Budget Commission.

An appropriation to the said Research, Planning and Development Board for each fiscal year of its operation has been appropriated from the State Treasury to the extent of the sum of \$15,000.

The Chair: Thank you, Dr. Parker. The Chair will recognize Dr. William Weston, Jr.

(Dr. William Weston, Jr., read a report "South Carolina Study on Child Health Services," Sponsored by American Academy of Pediatrics, written by Henry W. Moore, M.D., Exec. Secretary for S. C.)

SOUTH CAROLINA STUDY ON CHILD HEALTH SERVICES

Sponsored by American Academy of Pediatrics

The American Academy of Pediatrics at its annual meeting in St. Louis in November, 1944, approved a plan of its "Committee on Child Health in the postwar period" to make a survey of the needs of the children of the United States and the facilities available to meet these needs. As *we all realize*, postwar planning for child care has received much attention during recent years from many organized groups and individuals throughout the country, culminating in legislation now before Congress. The Academy realizes that the responsibility for such planning rests *primarily in the hands of physicians themselves*, and it has launched the study of child health services in order *first*, to gather necessary facts from which well founded plans can be made, and *second*, to determine the extent and quality of services now available. Thus the physicians, unquestionably the ones who know what constitutes good care, and who for the greater part provide that care, have accepted the challenge to develop concrete constructive plans for medical services to children.

As a first step toward this objective, the Academy requested the U. S. Public Health Service and the Children's Bureau to undertake with the Academy a survey in every state to determine the needed information. Both of these organizations responded with whole-hearted support and have given the full time services of expert medical and statistical personnel and equipment. The study is financed by Academy funds, donations from various pharmaceutical houses, the National Foundation of Infantile Paralysis and various local sources. In South Carolina the State Health Department is furnishing office space and office supplies, which are being charged to the Child Health Survey.

One of the fundamental purposes of the present study is *to stimulate local groups to discover for themselves the needs of their own communities* and the facilities to meet those needs. Essentially, this means the collection on a vast scale of adequate and accurate data. While the members of the Academy are committed to carry out the task, *the success of this tremendous undertaking is the responsibility of individual physicians in every state and community.*

To obtain the complete picture of the existent child health facilities, data will be collected by means of questionnaires on every important aspect of pediatric medical care. Four major categories will be studied. First, information will be sought in each community concerning the availability of physicians and dentists, and the facilities for essential diagnosis and treatment of sick infants. Second, detailed information concerning pediatric care will be obtained from all hospitals. Third, the study will cover the extent and quality of all community health services, both official and voluntary. Fourth, pediatric education of physicians, both general practitioners and specialists will be studied. A national inquiry into the quantity and quality of pediatric training at all medical schools will be carried out by persons qualified in the field of medical education and will not be done by local state groups.

We cannot too strongly emphasize that the study is being done by doctors in their own field of work. It is not a study by a lay group, a foundation, or a government department. Nevertheless, many of these groups are most interested in the project and are helping the Academy in many ways. It must be emphasized that the study is in no way connected with the many plans which have been proposed for

medical care, nor related to any of the bills now before Congress, which relate to medical care. The Academy takes the view point that the important thing is to find out on a nation-wide basis what care American children receive and what facilities for medical care are available. Only on such a foundation can sound and intelligent planning for the future be built.

The South Carolina study of Child Health Services is under the direction of the State Academy Chairman, Dr. William Weston, Jr. The South Carolina Pediatric Society has unanimously voted to undertake this study, and the South Carolina Health Department is cooperating in every possible way to insure its success. While the bulk of the responsibility and work must necessarily fall upon the pediatricians of the State, this study cannot succeed without the cooperation and backing of the South Carolina Medical Association and the practicing physicians of this State. In the near future, each practicing physician in the State will be sent a one page questionnaire and asked to promptly complete and return it to the State Office.

The importance of this study cannot be too strongly stressed. It is the first attempt of an organized group of medical men to inquire into its own affairs. As the Executive Secretary of this state, I request the full cooperation of every physician in the State, and I am confident that that cooperation will be forthcoming. On behalf of the Academy Chairman of this State, I should like to ask for full endorsement of the study of Child Health Services by the South Carolina Medical Association.

Henry W. Moore, M.D.

Executive Secretary for South Carolina

Committee for Study of Child Health Services: Warren R. Sisson, M.D., Chairman, 319 Longwood Avenue, Boston 15, Mass.; Allan M. Butler, M.D., Henry F. Garrison, M.D., Henry F. Helmholz, M.D., Lee Forrest Hill, M.D., Joseph I. Linde, M.D., Arthur H. London, Jr., M.D., Joseph S. Wall, M.D., James L. Wilson, M.D.

Advisory Committee: Joseph S. Wall, M.D., American Academy of Pediatrics; Martha M. Eliot, M.D., U. S. Children's Bureau; George St. J. Perrott, U. S. Public Health Service.

Executive Staff: Address: 7950 Rockville Pike (Bethesda Station), Washington 14, D. C., John P. Hubbard, M.D., Director; Katherine Bain, M.D., U. S. Children's Bureau; Montgomery Blair, Jr., M.D., American Academy of Pediatrics; Rollo H. Britten, M. Sc., U. S. Public Health Service; Rachel Spinney, M. S. P. H.; Charles L. Williams, Jr., M.D., M. P. H., U. S. Public Health Service; Elizabeth Lammie, Administrative Secretary.

The Chair: You have heard this report, what will you do with it?

Dr. Weston: The State Dental Association endorsed it yesterday and made some very complimentary remarks about it.

Dr. Price: As a pediatrician I know what this will mean to South Carolina, and all they are asking of us this afternoon is that we heartily endorse the program. As a pediatrician I so move.

(This motion was seconded.)

The Chair: Is there any discussion? (There was none.) The motion was voted upon and unanimously passed.

The Chair: At this time the Chair will recognize Dr. F. C. Locke, Chief Veterans Administrator, of Columbia, S. C. Dr. Locke.

(Dr. Locke read an appeal for doctors for their aid in the Veterans' Administration.)

Gentlemen:

It is indeed a rare privilege for me to have the pleasure of speaking to this brilliant gathering of South Carolinians today—a group of gentlemen distinguished in a great profession. As I look about this audience, noticing so many dyed-in-the-wool South Carolinians, I am reminded of a story which is going the rounds currently, which I would like to pass on to you. Being somewhat of a newcomer to this community myself, the story holds a personal interest.

About 1898 or 1899 a Bostonian came south. Like many other New Englanders, he succumbed to the charms of South Carolina, and especially of the city of Charleston. So he decided to locate in Charleston and enter business. Last year this gentleman died, leaving behind him an enviable personal, and successful business record. The Charleston News and Courier, ever alert to give honor where honor is due, eulogized him in an editorial and lamented his passing. In concluding its tribute, however, it is supposed to have said, "Although Mr. Smith lived amongst us only 46 years, there are times when we like to think of him as one of us . . ."

In my brief talk today, I wish to bring to your attention the matter of some 220,884 South Carolinians—those brave young men whom we saw marching away to the battlefronts of the world only a few short years ago. Many have returned now, victory bright upon their faces. Many more will return during the months and years which lie immediately ahead. They are our heroic veterans—our own sons, our families and our neighbor's sons who have made the peace of today possible for all of us who remained at home while they were fighting a war which was our war, too.

The Veterans Administration, never giving way to doing anything which it undertakes, half-heartedly, has set a great goal for itself insofar as hospitalization and medical attention for our veterans is concerned. In taking over the chief post as director of medicine and surgery in the Veterans Administration, Dr. Paul R. Hawley laid down our objective—a medical service second to none in the world. Now remember that—second to none in the world.

Now words and phrases can be mighty high-sounding. They can roll easily off an irresponsible tongue. They look good on paper; sometimes they can sound pretty good over the radio. But making a pledge to some 12,000,000 war-weary young men and women and keeping that pledge, is quite another thing.

And this is where you come into the picture. Without your full-fledged co-operation, without your never-failing assistance, we cannot keep the faith, our promise to those millions of veterans to whom we owe all we have, and shall have, in our time.

Right now, in the five states comprising this Southeastern area—South Carolina, Georgia, Florida, Alabama and Tennessee—we have an urgent need for a minimum of approximately 375 physicians. More will perhaps be needed for administrative work, adjudication of pensions, and so on. As more veterans are forced to seek hospitalization and all types of medical attention, this need will grow accordingly. But we will speak only of our needs of today.

As of April 25th, of this year, there were 576 veterans in the VA hospital in Columbia. Sixty-six others, sorely in need of hospitalization, have been waiting anywhere from one to 20 days for admittance. Forty-six veterans have been waiting from 21 to 40

days; as many as 145 men have been waiting longer than 41 days.

Now right here let me say that we are able to admit at once all those veterans who are critically ill of service-connected injuries. None of these are turned away. But we have a great number of other veterans who need treatment and various types of medical attention, who will get it only as soon as we can locate enough doctors to treat them. Until we do get this required number of doctors, the situation cannot be satisfactorily adjusted. Thus, the men who offered their lives for you and me, must mark time until a sufficient number of doctors can be recruited for this Veterans Hospital. That is not a prideful situation. It is a most lamentable one—one which, perhaps, some of you gentlemen here, can help the Veterans Administration overcome.

Let us put ourselves in the places of these returning veterans. Suppose you and I had been wounded in Germany or France—suppose we had fought our way up through the bloody mountain passes of Italy, or fallen on a shell-ridden beach at Okinawa or two Jima—what would you and I think of a country, or a state like South Carolina not having adequate facilities to take care of us when we beat upon the doors of our local Veterans hospital? What would we think? . . . We would think exactly what they are thinking of us today. And it isn't a pleasant thought, I can tell you.

These young men, as I have pointed out to you, have been promised the best medical care in all the world. The most crying need we have today is for more and more doctors. We can build hospitals or get them from the Army. We can buy surplus army and navy equipment and adequate supplies. But we can't requisition surplus doctors.

This is a situation which only you gentlemen can remedy. It is within your power, within your power alone.

Doctors in the Veterans Administration automatically have at their command the finest laboratories in the world for the treatment of all forms of cases; they have the advantage of consultation with this nation's foremost physicians in both public and private fields. New regulations give VA physicians financial and leave advantages which are highly attractive. Original appointments carry salaries and status equivalent to that of commissioned officers in the armed services, in ranks comparable to first lieutenant through brigadier general. To this pay is added a premium of 25 per cent for specialty board ratings.

What are these salaries immediately available to the doctor offering his services to his country and his fellow citizens in a Veterans Hospital? In many ways they are very lucrative. The lowest salary bracket begins at from \$3640 to \$4300. The highest pay is \$9800—which, with 25% premium for a specialty board rating may bring that sum to \$11,000 per annum. These, gentlemen, are good salaries in this, or any other day. In addition to a generous period of annual leave, there are numerous other benefits available to you, such as retirement, and exceptionally satisfactory living quarters.

All of you can help with your co-operation. Your moral support of VA's program is needed.

Those of you who consider this service favorably may well find it a career worth while. If you do, this is the time to act, because original appointments are offered now at the top grade dependent only upon qualifications.

After the meeting I will be at ----- where I shall be glad to see any of you who wish

further details about the Veterans Administration's department of Medicine and Surgery, and I shall remain there as long as you wish to discuss this highly important matter.

This call, or solicitation, for experienced doctors to assist the Veterans Administration in making good its promise to 12,000,000 veterans of the best medical care in the world, is for your full-time services; or for a part-time appointment; or upon a consultory, or fee basis. So urgent is the need for doctors, that I can tell you that all groups, whether full, part-time or on a fee basis, are sorely needed. If you could visit the hospital in Columbia or the hospitals elsewhere in the southeast—and see the constant stream of applicants for admission; look into their eyes and see the struggles which have been theirs—struggles which took them through jungles and deserts and mountains—you could but think seriously upon this call which I am making to you today.

These 12,000,000 young men of America failed us in no quarter. They offered their all for us; we cannot let them down—not today, nor tomorrow, nor ever.

Dr. Locke: I would like to add this to that statement about appointments at the present time. These appointments can be made in any of these grades up to and including the highest salary grade names, and it can be done until the quota is reached; after which, there will never be such an opportunity for such appointments. It so happens that I am acting as Chairman of the Board for these five states that pass on qualifications for these doctors. The ones with us now are the ones who apply.

The Chair: Thank you, Dr. Locke.

The Chair: The Report of Committee for Study of Medical Service Plans—Dr. Hugh Smith, Chairman.

Dr. Hugh Smith: I will read to give you an idea of what is underway. The work hasn't gone far enough to offer any concrete plan to the House.

The Chair: Thank you, Dr. Smith. Report of the Committee on Scientific Work—Dr. J. D. Guess.

Dr. Guess: As Chairman of the Committee on Scientific Work I want to thank every man for so appearing. I wish to state that our Committee was sorry that some of you who wanted to appear could not find a place on this program. We had more papers offered than we could handle. I want to thank Dr. Zemp and Dr. Mead for their assistance in this work.

The Chair: Report of the Committee on Legislation and Public Policy—Dr. Mordecai M. Nachman.

Dr. Nachman: The Committee on Legislation and Public Policy did not function as a committee this year. When first appointed we hoped we could get a Basic Science law passed, but we were advised not to bring such a bill before the legislature at this session because the Medical Association had too many other matters pending there. We just supported these special committees and endeavored to help them to pass this other important legislation. It is our hope this coming year that a special committee will be appointed with Dr. Price and Mr. Meadors, as members, to see that South Carolina does have a Basic Science Law.

The Chair: Report of the Committee on Postwar Planning, Dr. William H. Kelly, Chairman.

Dr. William H. Kelly: I transmitted this report to the other members of the committee, there has

been two assents and no dissents. It is our feeling that problems which relate to reconversion to a peacetime basis already have been required to be met before this report is given. (Report is read.)

REPORT OF THE COMMITTEE ON POSTWAR PLANNING

The Committee on Postwar Planning has only two recommendations that relate to the problem of reconversion of medicine to a peacetime status.

First, we suggest each of the unit societies that has not so done upon vote release to the local press the names of returning veterans along with the statement that the members request former patients of these physicians to return to their care.

Second, with reference to those physicians whose postgraduate training was interrupted by military call, we suggest that the Secretary of the Association communicate to accredited hospitals of the State the recommendation from this body that returning veterans be given preference in house staff appointments, that they be assisted in securing their share of the Federal appropriation under the so-called "GI Bill of Rights," and that enlargement of resident hospital staffs be limited in the interest of maintaining standards of postgraduate training.

In the broadest sense post-war planning may be interpreted to include other problems not strictly of reconversion but matters that have become pointed during the wartime years. Of these the one that looms largest on the post-war horizon is the proposed Federal panel system. This and similar matters are more nearly within the domain of other committees. Without intent to trespass the Postwar Planning Committee concurs that the extension of Federal Subsidy will probably be best limited through the working out of more effective State plans for medical care. In the recent field survey of medical training in South Carolina by the George Peabody Institute Committee recommendations were made toward elaboration of an overall program for the State. The Committee respectfully suggests that this matter be zealously pursued.

The Chair: Report of the Committee on Postgraduate Medical Activities—Dr. W. S. Judy, Chairman.

Dr. W. S. Judy: There is no need for any lengthy report. We have had a meeting and aside from the things embodied in Dr. Kelly's report, the outstanding postgraduate work is the Refresher course at the Medical College, and since this had its own committee from the Alumni Association and will be discussed tomorrow, we feel there is no need going into it at this stage.

The Chair: We will now have the Report of the Committee on Historical Medicine—Dr. J. Warren White, Chairman.

Dr. J. Warren White read his report.

COMMITTEE ON HISTORICAL MEDICINE— S. C. MEDICAL ASSOCIATION 1946

Nothing has been done this last year by your Committee except for discussing ways and means of obtaining material for a report for the 1948 Centennial Session.*

Appeals for material for assembling of an appropriation history of the Association and its component County Societies has in general been unsuccessful, but in some instances, such as the work being done by Dr. Robert Walker, and some work and a brief report by the Greenville County Society, as seen

in their last Bulletin, a start has been made.

It is suggested that a questionnaire with stamped addressed return envelopes be sent to various senior members of our society and others who might be considered as especially interested for information as regards the origin and development of the County Societies. This should include, of course, a history of the establishment of the District Organizations and parts played in the American Medical Association and Southern Medical Association by members from South Carolina.

Mention of important medical contributions by present or past members of the South Carolina Medical Association should be made as well as special activities during the times when this nation has been at war.

All of this will require an expenditure of a certain amount of cash, and the Committee feels that at least \$1,500.00 be appropriated from the Association treasury or better by some extra levy on each member. Published copies of such a history would, of course, be permitted for each member and would be a basic record to which, from time to time, new chapters will be added.

Instead of the President appointing an Historical Committee each year, it is suggested that a permanent Commission of five or less be elected by the Association for the express purpose of assembling this history and that it be headed by Dr. Joseph I. Waring, who has already done so much along this line, and is eminently fitted by past accomplishments to bring this important project to a successful conclusion.

The Chair at this time will recognize Dr. Jim Young for an announcement.

Dr. Jim Young: (Dr. Young made an announcement relative to the Piedmont Graduate Assembly to be held in Anderson this fall, stating that the entire program would be devoted to the study of Cancer.)

The Chair: The next order of business is the election of officers. The Chair will receive nominations for President-Elect.

Dr. Douglas Jennings (after being recognized): Gentlemen, it seems fitting that the 1948 meeting of this Association should be held in Charleston, where this Association was born 100 years ago. Since the first president of the South Carolina Medical Association was a Charlestonian it seems fitting that we elect as President-Elect now a man who would preside over the meeting in Charleston in 1948. The Charleston men have unofficially selected a man and it becomes my privilege to place his name in nomination. This is a man who has never held office in the State Medical Association, but has been very closely identified with the Medical School as a member of the faculty as a teacher since 1918. He has recently returned from some three and one-half years service in the army, entering as a Major, returning as a Colonel. He has recently been elected Professor of Neuropsychiatry at the Medical College, which has been made a full time teaching department on the same level with the Departments of Medicine and Surgery. It becomes my privilege and pleasure to nominate for President-Elect Dr. Olin B. Chamberlain, of Charleston.

The Chair: You have heard the nomination. Is there a second? (The motion is seconded by several.)

The Chair: Are there any other nominations?

Dr. Sease: I move the nominations be closed.

(This motion was seconded.) It was voted on and passed.

The Chair: It has been moved and seconded that this Association elect Dr. Olin B. Chamberlain from Charleston as President-Elect. All in favor of that motion please say "aye." (The motion was unanimously carried.)

The Chair: Dr. Chamberlain is our President-Elect. I will ask Dr. Nachman and Dr. Doug. Jennings to bring him in.

The Chair: We are now ready for nominations for Vice-President.

Dr. B. L. Smith (Recognized by the Chair): I would like to place in nomination a gentleman who has not been in our State many years but since he has been here he has done noble work for this Association and he has done, I think, one of the best pieces of work for our State Association that we have had in many years. He is a gentleman, he is a hard working man and I think would honor us as our Vice-President. I would like to place the name of Colonel W. H. Moncrief, head of the Tuberculosis Hospital in Columbia, as nominee for Vice-President.

The Chair: You have heard the nomination of Dr. Moncrief.

Dr. Hugh Wyman: I take great pleasure in seconding that nomination.

The Chair: You have heard the nomination which has been seconded. Are there any further nominations for Vice-President?

(A motion was made that the nominations be closed. This was seconded.)

The Chair: A motion has been made and seconded that the nominations be closed and that Dr. Moncrief be elected Vice-President, all in favor say "aye." (The motion was carried unanimously.) It is so ordered.

(Dr. Olin B. Chamberlain, escorted by Doctors Nachman and Jennings, is brought up on the platform.) (The House rises and applauds.)

Dr. Chamberlain: Mr. President, Members of the House of Delegates and friends of the South Carolina Medical Association, to say that I deeply appreciate what you have done today would be to understate my feelings. When one practices medicine in a state for about a quarter of a century, to finally receive the honor of being chosen to lead that state association is, as far as I am concerned, the crowning point of my life in medicine.

I am keenly aware that to be the leader of the State Medical Association in this day and time is not merely an honor, it is the duty, a responsibility and a challenge to the best that there is in us. I am very lucky and happy to be in such a position. I am also cognizant of the challenge to whatever abilities I may have. During the ensuing year, when I have the chance to see what the men who are in office ahead of me are doing, and are planning, I promise you that I will do everything that lies within my power to learn all I can about medicine, in its broadest aspects, and the rightful way in which it should develop so that when my time comes for office I shall give you the very best that I have in me.

Again I thank you.

(Applause)

The Chair: Nominations are in order for Secretary.

Dr. Nachman: May I nominate our Secretary, Dr. Julian Price.

(This motion was seconded and motion made that

the nominations be closed and that Dr. Price be elected Secretary.)

The Chair: You have heard the nomination and the motion that our present efficient secretary be put back and held in harness. There is a motion before you that the nominations be closed and that Dr. Julian Price be elected your secretary. All in favor say "aye." (This was passed unanimously.)

The Chair: According to this agenda we have to have a Treasurer.

Dr. Wyman: I nominate Dr. Julian Price. (This nomination was seconded. There was a motion that the nominations be closed and this was seconded. The question was put and Dr. Price was elected unanimously as Treasurer.)

The Chair: We now come to the election of Councilors. The term of Dr. R. B. Durham (Second District) expires this year.

Dr. Durham (Recognized): I place in nomination the name of Dr. O. B. Mayer, of Columbia, as Councilor of the Second District.

Dr. Zemp seconded Dr. Mayer's nomination. (Motion was made that the nominations be closed. This was seconded.)

The Chair: It has been moved and seconded that Dr. O. B. Mayer, of Columbia, be elected as councilor from the Second District. All in favor of this motion say "aye." (This motion passed unanimously.) It is so ordered.

Councilor of the Fifth District, the term of Dr. Roderick Macdonald expires this year.

Delegate: I would like to nominate Dr. Macdonald to succeed himself. (This nomination was seconded; motion was made and seconded that the nominations be closed; the vote was taken and Dr. Roderick MacDonald was unanimously elected to succeed himself as Councilor of the Fifth District.)

The Chair: The Eighth District, the term of Dr. George Truluck expires this year.

Dr. Truluck: I nominate Dr. L. P. Thaxton, of Orangeburg. He was councilor when called into the Service. (This nomination was seconded.)

The Chair: You heard that; all in favor of this nomination please say "aye." (The vote was unanimous and the Chair so ordered.)

The Board of Medical Examiners, the Second District, the term of Dr. George R. Wilkinson expires this year.

Dr. Guess: I move that Dr. George R. Wilkinson be elected to succeed himself. (This motion was seconded; it was passed unanimously and was so ordered.)

The Chair: Board of Medical Examiners of the Fourth District, the term of Dr. W. R. Tuten expires this year.

Dr. Truluck: I move that Dr. W. R. Tuten be elected to succeed himself. (This motion was seconded, the vote was taken and was unanimous and it was so ordered.)

The Chair: The place of meeting for next year is next.

Dr. Stokes: It is my happy privilege as a member of the Pee Dee Medical Society, composed of seven adjacent counties, to ask the State Medical Association to meet here in Myrtle Beach next year and to allow us to be your hosts.

Dr. Nachman: I move that we accept the Pee Dee Medical Association's invitation.

The Chair: You have heard the invitation and you have heard the motion.

Dr. Wilson: I second Dr. Nachman's motion. (The question was voted on and unanimously passed.)

The Chair: It is so ordered.

Dr. A. T. Moore, of the Columbia Medical Society, recognized by the Chair: Gentlemen, in the absence of Dr. Milling I bring to your attention a motion that was made at our last business session of the Columbia Medical Society. We had a communication to the effect that in Washington the present library building, that houses the Surgeon General's Library, is in a terrible state of repair and a fire trap. Very valuable books are being carted out and stored in places of safety. It has been proposed to Congress that an appropriation be made for I think something like twelve million dollars to erect a suitable building in Washington to house this most valuable collection of books, the Surgeon General's library. We could scarcely get along without it. They asked our support and we made a motion to the effect that we were in favor of the project and our secretary was instructed to communicate this sentiment to the members of Congress, from our State. And we further moved that this subject be brought up before the House of Delegates today for your sentiments regarding this thing.

The Chair: You make a motion that we endorse the plan to better house the library?

Dr. Moore: Yes, sir, I make a motion that this body go on record as favoring the proposal in Congress to erect a suitable building for the Surgeon General's Library and that our Secretary be instructed to communicate this to the delegates in Congress from our State.

The Chair: You have heard the motion; is there a second? (The motion was seconded by Dr. Guess.)

The Chair: Is there any discussion?

Dr. Wilson: The Medical Society of South Carolina some weeks ago instructed me as secretary to communicate with our Senators and representatives in Congress to this effect. It is not often that politicians commit themselves but the morning after I wrote these gentlemen I got telegrams from all three saying they were in thorough accord with us and would do their utmost to bring about the needed legislation. I am heartily in favor of the State Medical Association likewise endorsing this project.

The Chair: Any further discussion? (There was none, the vote was taken and unanimously passed.) It is so ordered.

ADJOURNED

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Florence, S. C.

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Office of Publication: (In care of the Editor) -----
Subscription Price -----

Florence, S. C.
\$3.00 per Year

JUNE, 1946

DR. ROBERT WILSON



Robert Wilson, M.D.

1867-1946

There are a very few men who, like sturdy and towering trees, have an air of indestructible permanence. When they finally go, there is a feeling of incredulity and the landscape seems eternally changed. Of such a small group was Robert Wilson. For over half a century, he was the unquestioned leader of scientific medicine in the state, and, indeed, in the Southeast. Educated at a time when medicine, as we know it today, was in its infancy, he studied and read indefatigably. His keen and logical Scottish brain absorbed facts and marshalled them in orderly fashion. During the last decade of the 19th century, he taught himself the new lessons of bacteriology and cellular pathology and became a physician of the tradition of Osler and McCrae and Janeway. He knew not only how to learn, but how to teach, and he early became a leader. The Medical School at Charleston, in spite of its many years of honorable existence, was then, at the turn of the century, a small and struggling institution, a private college without endowment and without income from taxation or other public source. Recognizing that it must share in the revitalizing and reorganization which was going on in American medical schools, Wilson set himself to the task, and, by 1913, after he had been dean for five years, he succeeded in having the school taken over by the state. In this way, organization of the college in a manner which brought it recognition as a Class "A" school was possible. For another thirty years, he guided its destiny with a strong hand.

A factual account of the life of Robert Wilson reflects his keen mind, his wide interests, and his great energy. It also indicates the recognition of his ability and the manner in which other men turned to him for advice and guidance. The following paragraphs are quoted from the Charleston News and Courier, May 21, 1946:

"Of Scotch, English, and French Huguenot stock, Dr. Wilson was born August 23, 1867, in Stateburg, a son of the Rev. Robert Wilson, a Confederate veteran, and his wife, the former Miss Ann Jane Shand. His father, a physician, entered the ministry and late

in life became the rector of St. Luke's Church.

"Educated in private schools, the College of Charleston and the South Carolina college (now the University of South Carolina), Dr. Wilson was graduated in 1892 from the medical college. Thirty-one years after he received his A.B. degree from South Carolina college, this institution, in 1918, conferred an honorary LL.D. degree upon him, and in 1922, the College of Charleston also gave him the LL.D. degree. The University of the South at Sewanee, Tenn., conferred the honorary degree of doctor of civil laws upon Dr. Wilson in 1926.

"Dr. Wilson was instructor in bacteriology at the medical college from 1889 to 1900, and adjunct professor from 1901 to 1903. He became professor in medicine in 1904, and dean in 1908, resigning in 1943 * * *. Since that year he had been dean emeritus, special lecturer on medical history and professor of medicine.

"The first bacteriologist of the city of Charleston, Dr. Wilson also served for many years as physician-in-chief of Roper Hospital. Dr. Wilson was a fellow of the American College of Physicians and a member of the American Medical Association. He was a past president of the Medical Society of South Carolina, the South Carolina Medical Association, and of the Southern Medical Association. He was a member of the National Association for the Study and Prevention of Tuberculosis, American Climatological and Clinical Association, the Tri-State Medical Association of the Carolinas and Virginia, and the American Society of Tropical Medicine.

"Prominent in medical affairs of this state during most of this century, Dr. Wilson had served at the head of most medical organizations in the area. He was head of the state board of health from 1907 to 1939, and in 1939 was presented the American Legion's plaque for distinguished service to the state. He played a leading part in the development of Roper Hospital."

Robert Wilson's tastes were simple and his life by present day values, austere. However, there was none of the prig in him. He saw into the foibles of men and viewed them with tolerant understanding. Reading was his greatest delight. Thoroughly grounded in the classics, and widely read in many spheres of knowledge, his conversation was a delight to those who knew him well. His sense of humor was tolerant and catholic and his comments on men and manners were pungent and full of dry wit.

Truly this was a great man. It has been given to few men in medicine in this state to wield the influence which Fortune assigned to Robert Wilson. The history of the medical institutions which he guided, and the position which he occupied in the affairs of South Carolina medicine is eloquent testimony to the manner in which he used that influence. The great majority of physicians in this state owe, in large measure, whatever scientific ideals they have to this teacher. His example was ever before them.

Those who were present at the 1946 meeting of the State Association, at Myrtle Beach, recall the

spontaneous burst of enthusiasm and affection which greeted the mention of his name, and how eagerly the entire audience rose to their feet to render him honor. It is well that he attended this meeting and received renewed proof of what his former pupils thought of him. Today, in the hearts of all of us, is the conviction that a great man has gone from among us, an unusual man, whose like will not be soon seen again.

O. B. Chamberlain

OUR NEW VICE-PRESIDENT

Col. Wm. H. Moncrief, Superintendent of the South Carolina Sanatorium, was born at Greensboro, Georgia. He attended the public schools of Atlanta and received his medical degree from Emory University. Upon completion of his internship at Grady Hospital, he was appointed resident physician at St. Joseph's Infirmary.

While engaged in private practice in Atlanta, Colonel Moncrief became attracted to the army medical service. He won a commission and was appointed First Lieutenant and Assistant Surgeon in the regular army. Training in surgery, he practiced that specialty wherever the exigencies of service permitted. This resulted in recognition and appropriate assignments as Chief Surgical Service and Operating Surgeon at various hospitals.

During World War I, working with Dr. Alexis Carrel at Rockefeller Institute, he worked out the United States specifications for the equipment and formulated the rules for our army's use of the Carrel-Dakin method treatment of war wounds.

Later, while in charge of the organization of the Division of General Surgery in the office of the Surgeon General of the army, he was ordered to France. There he commanded the Mesves Hospital Center. For his able management of this tremendous hospital center of 25,000 beds, Colonel Moncrief was awarded the Distinguished Service Medal.

At the time of his retirement Colonel Moncrief held the distinction of having commanded and directed the administration of more hospitals than any other man in the army. Among these were Fitzsimmons General Hospital, Denver; Wm. Beaumont General Hospital, El Paso; and Walter Reed General Hospital, Washington.

He came to the South Carolina Sanatorium on his retirement from active service, the last four years of which he was in command of the Army and Navy General Hospital at Hot Springs, Ark. Assuming the superintendency of the Sanatorium in the year following the opening of the new hospital building in 1938, Colonel Moncrief has rapidly expanded all branches of service. Under his management the bed capacity has increased from 440 to 550 beds and the waiting list of applicants has been reduced to a minimum.

Colonel Moncrief is a fellow of the American College of Surgeons, fellow of the American College of Chest Physicians, member of the Trudeau Society, director at large of the National Tuberculosis Association, and a director of the South Carolina Tuberculosis Association.

POSTGRADUATE SEMINAR

The Annual Postgraduate Seminar of the Alumni Association will be held in Charleston November 5, 6, and 7, 1946.

Your committees earnestly request your early suggestions as to speakers, subjects, and as to the general arrangement of the program. Please write at once to Dr. D. Strother Pope, Columbia, S. C., or to the local committee in Charleston, in care of Dr. J. I. Waring, 82 Rutledge Avenue Zone 6, as invitations to speakers must be sent out within the next few weeks.

Since the constitution of the Alumni Association of the Medical Association states: "any graduate of a grade A Medical College, licensed to practice in South Carolina and in good standing with his County Medical Society shall be admitted to this Association, if he so desires" he is also entitled to receive a copy of the *Bulletin*. If you are not receiving your copies or know of anyone who is entitled to get them but is not, this office would appreciate receiving the additional name and address. Send the information to: The Library, Medical College of the State of South Carolina, 16 Lucas Street, Charleston 16, S. C.

On May 1 the Finance Committee of the Alumni Association recommended that the dues of the Alumni Association be \$5.00 per year and that in addition a *voluntary* contribution of \$15.00 per member be suggested. This voluntary contribution shall be placed in the Special Speakers fund and shall be used solely for post-graduate purposes. This recommendation was passed by the Alumni Association.

The Finance Committee is composed of Dr. Decherd Guess, Chairman, Dr. Robert Hope, and Dr. Archie Sasser, with President Judy and Secretary and Treasurer Hanckel as ex-officio members.

It is urgently hoped that every member of the S. C. Medical Association will be an active Alumni member and that as many as possible will contribute \$15.00 or more towards building a Post-graduate Seminar of real magnitude.

D. Strother Pope, M.D.,
Chairman of Post-Graduate Com.

SOUTHERN MEDICAL

The Executive Committee of the Council of the Southern Medical Association, at a special meeting in St. Louis on May 13, accepted the invitation of the Florida State Medical Association and the Dade County (Miami) Medical Society to hold the next annual meeting of the Southern Medical Association in Miami, November 4-7. Local arrangements, including the appointment of committees, selection of hotel headquarters and hotels to be used, and the method of handling hotel reservations, will not be consummated for another six weeks, at which time

complete information will go forward to you. Jot down NOW in your appointment book—Southern Medical Association Meeting, Miami, Florida, November 4-7.

COMPULSORY BLOOD TESTS

At the last session of the General Assembly legislation was passed requiring serological tests on all pregnant women. Since this act will affect every physician in the state who deals with obstetrics we publish it in full.

AN ACT

To prevent the Occurrence of Congenital Syphilis in Unborn Children by Requiring Serological Tests for Discovery of Syphilis in Pregnant Women, to Provide Penalties for Violation of the Provisions Thereof, and to Provide for the Payment of Expenses Necessary in Carrying Out the Provisions Thereof.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Every physician attending pregnant women in the State for conditions relating to their pregnancy during the period of gestation and/or at delivery shall, in the case of every woman so attended, take or cause to be taken a sample of blood of such woman at the time of first examination, or within three days thereafter, and shall submit such sample to an approved laboratory for a standard serological test for syphilis. Every other person permitted by law to attend pregnant women in the State, but not permitted by law to take blood samples, shall cause a sample of blood of such pregnant women to be taken by a physician duly licensed to practice medicine and surgery, registered nurse or laboratory technician authorized to take blood for blood tests, and have such sample submitted to an approved laboratory for a standard serological test for syphilis.

SECTION 2. For the purpose of this Act a standard serological test shall be a test for syphilis approved by the State Health Officer of South Carolina, and shall be made at a laboratory approved to make such tests by the State Health Officer of South Carolina. Such laboratory tests as are required by this Act shall be made on request without charge at the South Carolina State Board of Health.

SECTION 3. Any person who violates the provisions of this Act shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than One Hundred (\$100.00) dollars or imprisonment for not more than thirty (30) days.

SECTION 4. The South Carolina State Board of Health shall provide the necessary printing, clerical and other technical assistance involved in the administration of this Act or any other expenditures necessary in carrying out its provisions and purposes.

SECTION 6. This Act shall become effective and in full force on July 1, 1945, after its approval by the Governor.

Approved April 1, 1946 by Governor Williams.

NEWS ITEMS

Dr. Pearce Bailey, a graduate of the Medical College of the State of South Carolina, has been named as chief of the neurological division of the Veterans Administration's neuro-psychiatric service in Washington.

Dr. Samuel O. Cantey, Jr., has opened his offices in Marion for the practice of general medicine.

Dr. Robert L. Moore, of Columbia, has become associated with Dr. John S. Lewis, a surgeon and general practitioner, in Hickory, N. C.

The American Physiotherapy Association is holding its 25th anniversary conference at Blue Ridge, N. C., from June 16 to June 21. The Carolina Chapter has extended a cordial invitation to the members of the S. C. Medical Association to attend any of the meetings of this conference.

Dr. J. Rufus Bratton has opened his offices in Rock Hill for the practice of diseases of infants and children.

Dr. Katharine Baylis MacInnis, Columbia, South Carolina, who is an allergist, is reading a paper at the meeting of the American College of Allergists in San Francisco at the meeting a few days prior to the meeting of the American Medical Association. The subject of Dr. MacInnis' paper is "Urticaria and Contact Dermatitis due to the handling of Penicillin."

CHESTER COUNTY MEDICAL SOCIETY

The Chester County Medical Society held its regular monthly meeting at the Pryor Hospital Tuesday night, May 7th, with Dr. Wylie presiding.

Dr. Wallace gave a report on the South Carolina Medical Association Meeting at Myrtle Beach on April 30th, May 1st, and 2nd. Dr. Patterson discussed the urgent need for Nurses for the Hospital.

Dr. Hennies introduced the guest speaker, Dr. W. B. Bradford of the Bradford Clinic of Charlotte who spoke on several topics including "Sterility and

Its Cause," "Habitual Abortion," "A Case History of Hydatidiform Mole," "German Measles in the First Three Months of Pregnancy," and "The RH Factor."

After this talk, all the doctors joined in a general discussion of these topics. Doctors present included: Dr. J. N. Gaston, Jr., and Dr. J. N. Gaston, Sr., Dr. V. P. Patterson, Dr. W. R. Wallace, Dr. A. M. Wylie, Dr. W. J. Henry, Dr. G. A. Hennies, Dr. R. D. Hicks, Dr. W. B. Bradford, and Dr. Malcolm Marion, Senior at the South Carolina Medical College.

DEATHS

James Luther Ward

Dr. James Luther Ward, 67, for almost half a century a practicing physician in Greenwood County, died at his home on May 10. A graduate of the Medical College of the University of Georgia in the class of 1898, Dr. Ward began the practice of his profession in his home community and continued there. He is survived by his widow, the former Miss Elise Hipp, and one son, Dr. James L. Ward, Jr., of Greenwood.

Cauthen Clyde Ariail

Dr. Clyde Ariail, 56, died on May 19, after several months of failing health. He was graduated from Wofford College and from the Medical College of the State of South Carolina in the Class of 1913. For the past thirty years Dr. Ariail had practiced his profession in Greenville. Surviving are his widow, one son and three daughters.

James Andrew Rutledge

Dr. James A. Rutledge, 84, died at his home in Heath Springs on May 15. He was one of the county's most prominent and oldest physicians. Dr. Rutledge was graduated from the Medical College of the State of South Carolina in 1889. He is survived by his widow, one daughter, two sons, and several grandchildren.

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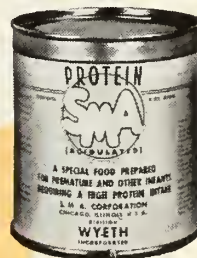
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Mrs. S. Harry Ross, Anderson, S. C.
President Woman's Auxiliary, 1946-1947

Mrs. S. Harry Ross of Anderson was installed as President of the Woman's Auxiliary to the S. C. Medical Association at the Convention held at the Ocean Forest Hotel, Myrtle Beach, May 1, 1946. Other officers installed were President-elect, Mrs. David F. Adcock, Columbia; First vice president, Mrs. J. W. Potts, Easley; Second vice president, Mrs. W. O. Whetsell, Orangeburg; Recording Sec'y., Mrs. J. C. Josey, Spartanburg; Corresponding Sec'y., Mrs. E. O. Hentz, Anderson; Treasurer, Mrs. J. L. Sanders, Greenville; Historian, Mrs. J. R. Desportes, Fort Mill; Publicity Secretary, Mrs. J. R. Young, Anderson; Parliamentarian, Mrs. H. L. Timmons, Columbia; Student Loan Fund Chairmen, Mrs. T. A. Pitts and Mrs. Vance W. Brabham; Treasurer Student Loan Fund, Mrs. M. Nachman, Greenville; Councillors: District No. 3, Mrs. W. C. Abel, Columbia; District No. 4, Mrs. W. H. Folk, Spartanburg; District No. 5, Mrs. J. L. Bundy, Rock Hill.

PRESIDENT'S MESSAGE

Mrs. S. HARRY ROSS, Anderson, S. C.
(Delivered at Myrtle Beach, S. C., May 2, 1946)

Your President is aware of the great responsibility before her, and pledges her devotion and loyal service. Life as we have known it over the past few decades has changed so greatly that each one of us now hesitates to occupy herself with anything new unless it be directly associated with health education. We have become accustomed to living in the present as though the future were a long way off. The fact is brought home to us that the march of our great

American Medical Association Auxiliary has been slowed down during the war years. This should not discourage us but rather should it cause us to realize that Auxiliary members have been recognized as valuable in their communities and have been chosen leaders in our country's struggle for the four freedoms.

Every member has a vital part in our Auxiliary. The individual member does not need to be active on the various committees to be a good member, but she can give her best effort to whatever work may be assigned. Support of all undertakings, faithful attendance at meetings, and suggestions for the continued good work of our organization is essential at all times.

The medical profession is facing the greatest challenge in its history. Compulsory or Socialized Medicine is making inroads into the private practice of medicine and the Auxiliary is the only group to definitely serve the Medical Society in combatting this propaganda.

More than ever before there is an urgent need to strengthen our organization and to organize new County Auxiliaries. It is your President's desire that many new members will be added to our list. This can best be accomplished by making this a year of personal service, imparting to prospective new members the importance and advantage of being an Auxiliary member. In gathering in the new members, let us not forget the old. Outside activities during the war period may have interfered with their interest in the Auxiliary; let us awaken that interest again.

Every effort should be made to promote the circulation of Hygeia. By making Hygeia available to schools, colleges, libraries, clubs, industrial plants and Veterans' Hospitals authentic health information is thus disseminated.

Let us have for our aim this year a Medical Auxiliary in each of the 46 counties in S. C. and let us be sure that no physician's son in S. C. who wants to be a doctor is denied this opportunity because of lack of money. Let us thoroughly investigate this.

We are impressed with the fact that we need very much a strong Health Committee since the glaring statistics during the war showed us that half of our boys were physically unfit for service. This is a great challenge to us.

Today all loyal Americans are experiencing victory and facing a world at peace. We welcome it, each in our own way. In this period of our country's reconversion, let us strive with renewed active service to maintain our Auxiliary's ideals. Success is purchased not with money, but with thought, effort and time.

Thus this personal appeal comes to each of you for your cooperation, for with it your president will have a confidence that will sustain her. "SERVICE TO OTHERS" is the message she leaves with you.

NEWS LETTER FROM WASHINGTON

May 24, 1946

BACK TO NORMAL ISN'T ENOUGH

Medical organizations throughout the country are getting back to normal *but that isn't enough*.

Many local medical societies which haven't had regular meetings since the war are getting back on schedule—*but that isn't enough*.

Spring is the usual season for many state and district medical meetings but the *usual meetings are not enough*.

Indeed nothing short of all-out, intense, well directed local medical organizations with active, functioning committees covering each key subject working as they have never worked before, is going to be enough to accomplish what must be accomplished if American Medicine is to meet the obligations placed on it and do the job outlined by the House of Delegates, the Board of Trustees, the Council on Medical Service and Public Relations and the other Councils and Bureaus of the American Medical Association.

First and foremost on the medical economic front, of course, is the defeat of the Wagner-Murray-Dingell bill which if passed would threaten the high standards of medical care which have made the American people the healthiest of any of the larger nations.

The second job is to get the Ten Point Program off the printed page and out of the esoteric realm of public relations down to the realism of public consumption. This program should be put into effect in each community.

KEEP UP TO DATE

It is the job of every doctor to keep posted on the developments with reference to this legislation. The best reference right now is the A. M. A. Journal—read the weekly resume of the Senate Hearings. These hearings are bringing out many an interesting expose of the forces behind this Bill. For instance the Chairman of the National Commission on Children and Youth testified for the Bill. Sounds like a big nation-wide group. But here is what questioning brought out. The Commission consists of a group of people appointed by Miss Lenroot and Dr. Martha M. Eliot of the Children's Bureau. Your patients should know about these tie-ups.

MOST URGENT NEED

The most urgent need in putting the Ten Point Program into action is—increased enrollment in prepayment medical care plans. A year ago the question was—how to get plans started? But today with plans organized in thirty-three of the forty-eight states and in process in another eight states, this question has been answered. In general the rate of growth parallels that of Blue Cross during its first few years.

The number of Blue Cross Plans grew from one to thirty-eight in the six years 1933-1938; the number

of medical care plans rose from four to thirty-seven in the seven years 1939-46. This growth is satisfactory but still doesn't obviate the fact that medical plans are six years behind Blue Cross. The groundwork—the facilities through which prepayment is available—has been laid. The job now is to get people to avail themselves of these facilities.

The growth in total enrollment of prepayment medical care plans to date also compares favorably with the early enrollment growth of the Blue Cross Plans. During the first seven years, the total enrollment of the Blue Cross Plans was given as 2,870,000. The first seven years for the medical plans have resulted in a total enrollment of 2,800,000. Comparatively then, the medical plans have, so far, grown as rapidly as the hospital plans grew. But being six years behind the medical plans should and must now enroll many times more rapidly than did Blue Cross. Everything favors this—the situation is a set-up for a big fast job. 21,500,000 Blue Cross enrollees await medical and surgical benefits.

A few plans are growing steadily and rapidly—but too many are just limping along, apparently satisfied with whatever enrollment falls their way.

Merely having a plan available *isn't enough*. The contracts must be sold—to groups via individuals.

This is not a job for the Plan executives alone. It is also a job for the medical societies, the doctors, the Council and the Associated Medical Care Plans.

One of the principal factors in the growth of prepayment plans will be the interest taken by the medical profession in the area in which any given plan operates. State and County medical society officers have a variety of means for stimulating this interest. In a few instances the State Journals or County Bulletins have made intensive efforts to stimulate the interest of their membership. Too often, however, the articles are tucked away or are confined to an uninteresting report on finances.

ACTIVITY NOTES

A Job for the Auxiliary

The Women's Auxiliary of the New York State Medical Society has taken up the job of "selling an idea"—the idea of voluntary medical insurance. A series of effective community meetings was developed and carried out by the local auxiliaries. A score of these auxiliary-sponsored meetings have been held. Community representatives are invited, the press is welcomed, and discussion from the floor permitted.

It Just Goes to Show

Via "Scottie" Saville, Ohio State Medical Association, we learn that The Columbus Dispatch, April 19, 1946, carried an article on a poll taken in five Ohio counties. The poll showed 85 per cent opposed to the President's proposed medical care program. It just goes to show that you can get polls for both sides.

Excellent Reading

In 1944 the Harvard Medical School inaugurated a new experiment in teaching. The program consisted of a series of seminars on medical economics and medical sociology with guest speakers invited to participate. These seminars have proved so successful that they have been continued during the past year. The New England Medical Journal has been featuring the lectures since January 9, 1946. They are recommended reading.

One Way to Do It

The Public Relations Committee, with M. H. Meadors as secretary, of the South Carolina Medical Association has been active this past month. Meetings with lay groups have been sponsored in every section of the State to discuss the Wagner-Murray-Dingell bill. A speakers' bureau, composed of doctors, was organized and each district councillor assigned the job of arranging for talks and meetings. Statements were issued to the press and half page ads run in the leading newspapers.

Another Way

The California Physicians' Service has joined together with three other non-profit plans and almost a hundred private insurance carriers to form the California Committee for Voluntary Health Insurance. The purpose: to coordinate the efforts of civic organizations, farm, business and professional groups, women's clubs, veterans' organizations and individual citizens in promoting voluntary health insurance. Their pamphlet, "The Fifth Freedom," is not only another way, it leads the way.

Still Another Way

The Health Advisory Council of the United States Chamber of Commerce is publishing a news letter entitled, "How Chambers of Commerce Are Attacking on the Health Front." It deals primarily with public health programs adopted by or planned for various cities and states. Copies may be obtained from the Chamber headquarters in Washington.

The Public Must Be Educated

Dr. Lawrence T. Brown of Denver hit a true note in a recent talk when he stated "The Public must be educated: To understand that the patient loses the most under socialistic medicine."

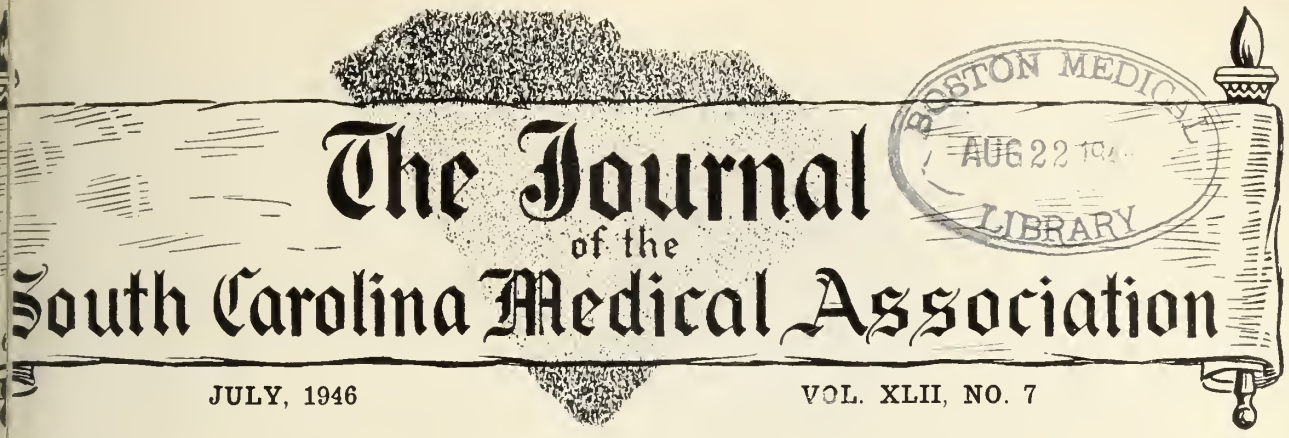
Along this same line it is interesting to note that the Committee on Medical Information of the Allegheny County Medical Society is distributing 62,500 pieces of literature through the retail druggists.

MISCELLANEOUS

Roy W. Mohler, M. D., a member of the Executive Committee of the Medical Service Association of Pennsylvania announced in a talk given in Philadelphia on May 9 that "the income levels established by the Medical Service Law of Pennsylvania, under which the Association operates, covers 98 per cent of the workers in the State with families." His statement was based on information from the Pennsylvania Department of Labor. This is certainly contradictory to the criticisms of the Wagner-Murray-Dingell bill proponents complaining about the income levels of voluntary prepayment plans. If this 98 percent figure is correct only 2 per cent can be charged an additional fee by the doctors.

**COUNCIL ON MEDICAL SERVICE AND
PUBLIC RELATIONS OF THE AMERICAN
MEDICAL ASSOCIATION**

52



The Journal of the South Carolina Medical Association

JULY, 1946

VOL. XLII, NO. 7

Article	Author	Page
A Proctologist's Message to the General Practitioner	Lonis J. Hirschman, M.D.	183
The Nutritional Status of the People of South Carolina	Julian P. Price, M.D.	186
Congenital Malformations Following Rubella in the Mother	Junius W. Davis, Jr.	190

Editorials — The Ten Point Program — News Items — Public Health News
Book Reviews — Deaths

BACKGROUND

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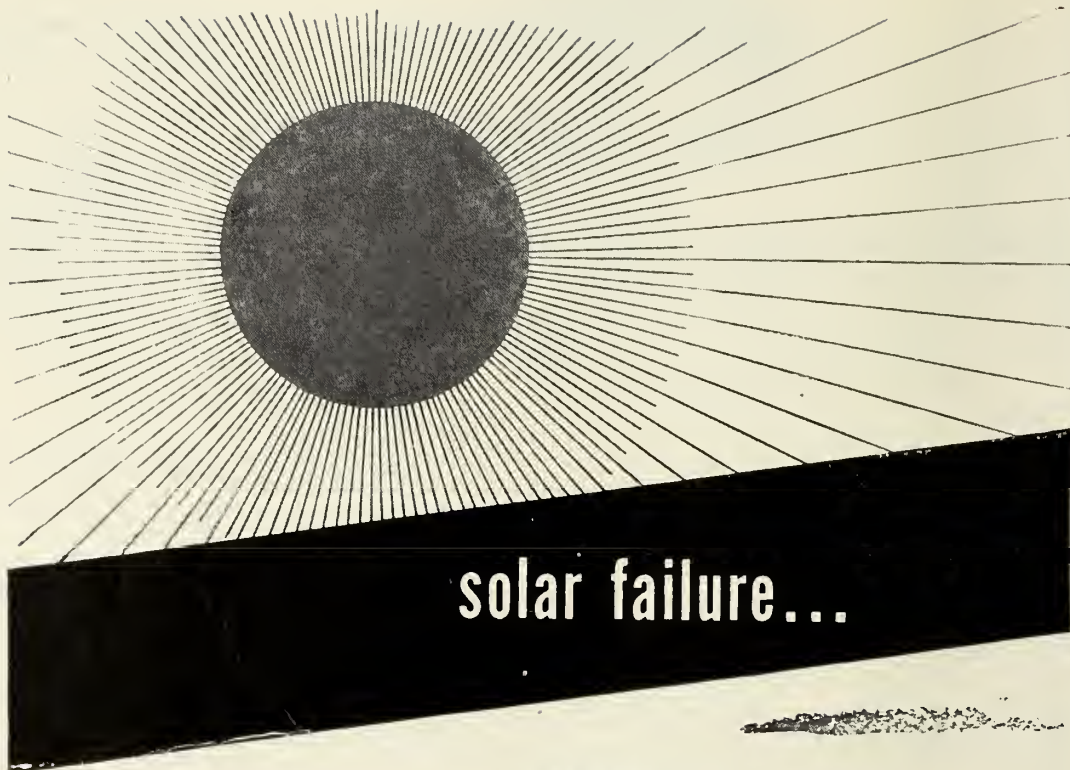
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1. Florida Health Notes 37, May, 1945.
2. Am. J. Dis. Child. 54 1227, 1937.



FINE PHARMACEUTICALS SINCE 1886

U P J O I N V I T A M I N S

OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA
Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879.
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

July, 1946

NUMBER 7

A Proctologist's Message to the General Practitioner

· LOUIS J. HIRSCHMAN, M.D.
Professor Emeritus of Proctology
Wayne University, Detroit, Michigan

I first wish to express my appreciation of your courtesy in inviting me to meet with you. As I have told Tom Brockman in the past, I would go a long way to meet those who saw fit to elevate him to the presidency of the South Carolina Medical Association—and so I have journeyed here. He requested me to give a short, practical talk which might be of interest to that great backbone of the healing arts—the general practitioner.

He is the man whom the patient first consults, as a general rule, and on his advice depends, in many cases, the health, happiness and comfort of his patients as well as suffering, misery and, sometimes—death.

The specialist would certainly be of little value to the human race if he himself had not had the benefit of some training in the general practice of medicine. Neither would his services be of much value if the general practitioner did not first, on painstaking examination of his patient, detect those deviations from normal health which would suggest to him the value and the necessity of consultation with one who specializes in a given field.

It is quite true that many conditions treated by the specialist can also be handled with equally successful results by the well-trained general practitioner. More and more are the medical schools and universities awakening to the fact that refresher and continuation courses in the various specialties are eagerly welcomed by the general practitioner.

Many of the State Medical Societies are fostering such postgraduate courses. My own State—Michigan—has been a pioneer in this respect. The benefits of such training are indelibly impressed on the public as time goes on. They are the ultimate beneficiaries of this added instruction in, at least, the fundamentals of most of the specialties.

Examination and Diagnosis

Diagnostic methods, which do not require complicated paraphernalia or involved procedures, are

(Presented at Myrtle Beach at a joint meeting of the Greenville County Medical Society and the Pee Dee Medical Society, April 30, 1946.)

being made available to the general practitioner of medicine and utilized by him for his greater advance in the science and the art of medicine, and guide him in the salvaging of many human lives as a result of prompt and early recognition of symptoms of disease which might otherwise progress beyond human control.

In the field of proctology, it seems to me we see far too many patients whose condition has progressed to a tragic extent merely because of a distaste or reluctance of some general practitioner to make a simple examination of the anus, rectum and sigmoid.

About 60% of the malignancies affecting the terminal portion of the alimentary tract are within easy reach of the examining finger. What an indictment it is on the family physician whose patient has been treated for simple hemorrhoids to find that a malignancy may be lurking just above and behind these internal hemorrhoids!

Every proctologist has had foisted on him the sad duty, too many times annually, to inform the patient and his physician that such a malignancy has either been treated, or is being treated for supposed hemorrhoids.

Many of those in my audience today conduct physical examinations for insurance companies and for employers of labor. Others, I am sure, are frequently called upon to make physical examinations of those patients who are health conscious, and desire these physical examinations annually or at more or less stated intervals.

A diligent examination of the organs of special senses is made—the chest is thoroughly explored—urine, sputum, and blood examinations properly made—the abdomen carefully palpated and the various reflexes checked. In female patients, a bi-manual

and specular vaginal examination may be made, but, in the male—unless the prostate suggests a digital examination, rectal examination is often omitted.

Unfortunately, in many instances, patients are still asked to lean over a chair or table and, if the examiner does not see any skin tags or other irregularities around the anal aperture, it is taken for granted there is no anorectal pathology.

The proctologist suggests that in every insurance examination, as well as in other physical checking up of the patient, not only a digital examination be made but a proctoscope inserted and used. It is a well-known fact that most cases of hemorrhoids are not detected by digital examination—they can only be visualized. The same is true of prolapsus and a number of inflammatory conditions of the rectum.

If one in fifty such examinations is rewarded by the discovery of a hitherto unsuspected early malignant lesion, the other forty-nine examinations are certainly worthwhile. Regardless of the fact that such an examination should be a part of the physical inventory, there are certain symptoms which make such an examination mandatory. Among these may be mentioned any change from the individual's normal peristaltic habits, the appearance of any type of discharge from the anal orifice—itching, burning, or peri-anal discomfort of any kind—sphincter spasm, tenesmus, or feeling of tightness or obstruction—elevations, depressions, swellings and erosions in the peri-anal region, protrusions, prolapsus and any other abnormal feeling of which the patient complains—and, most important of all—rectal bleeding.

Rectal Hemorrhage

Bleeding, of all symptoms, is the one important warning of impending danger. Too often patients, and even physicians, have regarded the symptoms of bleeding as being evidence of the presence of hemorrhoids.

It is true that hemorrhoids are the most common source of rectal bleeding, but too often hemorrhage may be a symptom of pathology of much more grave import. Many a patient has been doomed to his death because of the thoughtless administration of palliative measures for supposed hemorrhoids when the early carcinoma, which caused the bleeding, was allowed to progress to an inoperable stage.

How often have physicians turned away patients who complained of bleeding from the rectum by handing the patient a box of some suppositories which they have received as samples, and telling the patient—"Try these, I think they will help you!" Too often the patient will continue to purchase repeated supplies from the druggist on his own initiative and then, after weeks or months, will again consult his physician, when, too often, it is too late!

I believe that suppositories are very dangerous. They do not cure anything. They occasionally relieve

and lull the patient into a false sense of security until the golden opportunity of helping the patient is passed. Suppositories do not, in any event, place the medicament where it really comes in contact with the real pathology for a sufficient length of time to be of value, even as a palliative measure.

Most of the pathology for which suppositories are given is located in the anal canal. The suppository, which is composed mostly of cocoa butter, melts at body heat, and, if the patient is ambulant, this warm, oily mess seeps out and soils the clothing. If the patient is recumbent, the melted suppository follows the law of gravity and flows back into the ampulla where it does not affect the disease at all.

If the patient complains of a smear of blood on the stool or on the toilet paper and its appearance is accompanied by sphincter-spasm with throbbing pain, particularly aggravated after bowel movement, this, undoubtedly, originates from an anal fissure or anal ulcer.

Inasmuch as an anal ulcer is usually a fissure which has become chronic, its treatment is the same as for that of the original trauma or fissure. This means putting the sphincter at rest—incised at right angles to its fibers after the parts have been anesthetized by local block.

We do not believe that a sphincter should ever be put at rest by divulsion and certainly general anesthesia should not be used for any surgical procedure which can be performed so much better under a regional type of anesthesia.

Divulsion of the sphincter sufficient to put it at rest means tearing some of its fibers. It is far more advisable to incise fibers than to tear them.

There is no condition of the ano-rectal region where the symptoms of which the patient complains are greater in proportion to the size of the lesion than anal fissure.

Hemorrhoids

I do not intend to discuss the diagnosis and treatment of hemorrhoids at this time, but merely wish to leave one thought with you regarding hemorrhoids.

Too often I find that the practitioner does not make a distinction between internal and external hemorrhoids. Too often the proctologist still is called upon to treat patients who have been suffering from acute thrombotic hemorrhoids where both the physician and patient have been diligently trying to push an external hemorrhoid into the anal canal where it does not belong. It is amazing how often this happens in the best of regulated practices! It makes no difference how well one can reduce or push a hemorrhoid into the anal canal, if its covering is skin, it is an external hemorrhoid and belongs on the outside. Conversely, it makes no difference how far a hemorrhoid is prolapsed, if covered with mucous membrane, it is an internal hemorrhoid and belongs inside!

The trauma produced by the efforts of physician or patient to push an external hemorrhoid into the anal canal where it is alien, causes more suffering than the presence of the external hemorrhoid itself.

Here again I wish to reiterate—suppositories and ointments have never cured a case of internal hemorrhoids and never will. Various types of sclerosing therapy, particularly the injection of Quinine Urea, Phenol, or Sodium Morhuate Solutions have caused internal hemorrhoids to atrophy and have diminished or stopped bleeding, but the same conditions which produced the hemorrhoids in the same place will soon cause the symptoms to recur. Ultimately the patient will need a hemorrhoidectomy for permanent relief.

Carcinoma

One cannot leave the discussion of bleeding without mentioning that grave condition which is most often overlooked, particularly when hemorrhoids are diagnosed. As has been noted earlier in this paper, carcinoma of the colon and, particularly of the rectum, may be silent for quite a long period. Among its earliest symptoms and warning signals is the appearance of blood. When this is accompanied by changes in digestive and peristaltic habit, and the patient complains of fatigue or other deviation from his normal state of health, it is well to give the patient the benefit of a complete proctologic and radiologic examination of anus, rectum and colon. If this examination proves negative as far as malignancy is concerned, a great service has been done the patient.

In addition to the mistaken diagnosis of hemorrhoids when carcinoma is the major factor, one must, of course, realize that carcinoma may be accompanied also by hemorrhoids, fistula, and, not infrequently, polyposis. In fact, every polyp, particularly if sessile, should be viewed with grave suspicion, as it may be a pre-cancerous lesion.

Another tragic mistake in diagnosis, which is still too often being made, is that of "colitis." Several times a year I see patients suffering from carcinoma who have been treated for months for "colitis," dysentery, bloody flux, and chronic diarrhea. It behooves every practitioner to supplement his proctologic examination of every case of so-called "colitis" with manipulation, under the fluoroscope after administration of a barium enema, and, of course, make a complete roentgenological study before, during, and following the administration of the barium enema.

So-Called Colitis

Another condition which must not be overlooked in connection with "colitis" is colonic dysfunction which occurs in patients who have had previous abdominal surgery—more often in women. Distortion, angulation, misplacement, compression and obstruction of the colon are still too frequent a sequela of abdominal surgery.

Not infrequently women after a stormy confinement will develop intestinal adhesions which, by their presence, cause many cases of colonic dysfunction. The hyper-peristalsis and hyper-secretion caused by colonic irritation, which is usually extra-viceral, often misleads the physician. If, in addition, the patient happens to have a polyp or hemorrhoid which bleeds, blood-stained stools will further confuse and complicate the diagnosis.

Careful consideration of the patient's previous operative history and palpation of abdomen, particularly employing the tugging sign, will frequently disclose the presence of adhesions to the abdominal scar, the omentum and to other organs. Surgical relief of these adhesions and reperitonealization of the affected areas relieves the symptoms and cures the so-called "colitis" in a truly dramatic manner.

Sphincteric Injury

Another thought I would like to leave with you is about those patients who have been unfortunate enough to suffer some sphincteric incontinence as a result of peri-rectal abscesses, fistulas or unfortunate surgical results in the attempt to relieve these conditions.

You will note how respectful I am to the sphincter muscle. I feel that with the exception of damaging conditions such as occur following serious accidents or wounds which are received in combat, there is no excuse for fecal incontinence resulting from the severing of the sphincter muscle.

Where this has occurred we can offer hope to those who have suffered the loss of fecal control and have been condemned to diaper life.

In most instances, no matter how long the incontinence has existed, it is quite possible, through reconstructive plastic surgery, to restore sphincteric action and full control, in the great majority of these cases. This is particularly true when plastic operations are performed under caudal or spinal anesthesia.

Colostomy

One final message from the proctologist is on the subject of colostomy. There seems to be in the minds of a certain proportion of our profession a feeling that a colostomy is a disgraceful possession of a patient who has been affected with a carcinoma or other condition requiring an artificial anus.

Many thousands of lives are saved annually because of the ability of the proctologist or the surgeon to perform a satisfactory colostomy operation. Even a poor colostomy is a life-saving measure and is better than none in many cases.

It is not the possession of a colostomy which, in quite a number of cases, makes the patient feel like an outcast or a pariah; it is the lack of proper instruction on the part of his surgeon as to the proper care of his colostomy.

A properly constructed colostomy, properly cared for, keeps the patient on the job and allows him

to mingle with his fellowmen without embarrassment to himself or annoyance to others.

In addition to a centrally placed abdominal colostomy, there is a large and growing field for the perineal type of colostomy. Many patients who are fortunate enough to have a proctologist, who is in the habit of performing perineal colostomies in that 40% of the patients where it is perfectly safe, have much for which to be thankful.

If the carcinoma is located above the levator level, freely movable and not adherent, and the fluoroscopic examination discloses a large and freely mobile loop of sigmoid with a long meso-sigmoid, it is not necessary to sacrifice normal sphincteric control.

Whether by the perineal route or combined abdomino-perineal technique that portion of the sigmoid which many surgeons swing up into an abdominal wound can be brought down to the perineal level and sutured to the skin edges—in many instances, saving full sphincteric control.

The closing message of one proctologist to an audience composed largely of general practitioners is—more and more lives are being saved every year

because of early diagnosis as a result of early examination and the early indicated surgery being thus insured.

The number of patients who have been suffering from carcinoma of any part of the colon, especially the terminal portion, can expect a complete cure or a much longer lease of life if immediate operation is performed.

Give your carcinoma cases the benefit of the doubt. Assure them that a fair percentage can have normal functioning bowels in the normal site. Assure them that those who are unfortunate enough to have involvement of the sphincter still can have a stoma in the perineum which can be just as clean and just as easily cared for as that on the abdominal wall.

Inform your patients that in many instances it is no more of a detriment to life and happiness to have a carcinoma removed than to have a limb amputated.

If you will check yourself and ask—"What would I do if I had to be operated upon for carcinoma"—and, if you will give your patient the benefit of what could be done in your own case, then you will thoroughly live the Golden Rule and "do to others as you would be done by!"

The Nutritional Status of the People of South Carolina

(A Clinical Study)

JULIAN P. PRICE, M.D.

Florence, S. C.

(This paper was prepared by request and presented before the Conference on Nutrition, Clemson College, May 31, 1946. It is based upon the replies from sixty physicians in response to a special questionnaire. The author wishes to thank the following physicians for their aid in filling out the questionnaire:

Drs. J. H. Danner, Maxey Hook, Lee Milford, M. W. Beach, Spencer McCants, W. R. Wiley, A. C. Bozard, Paul Sasser, J. I. Waring, W. E. Hicks, K. B. Bultman, Ned Camp, Robert Stith, I. H. Grimbail, R. M. Pollitzer, J. G. Ulmer, Carroll Brown, Walter R. Mead, Dexter M. Evans, E. H. Thomason, Donald E. Michie, A. R. Johnston, Jack Jervay, Ben N. Miller, E. M. Hicks, J. M. Albergotti, R. E. Livingston, James J. Chandler, C. H. Blake, J. H. Pearce, A. W. Browning, Philip Assey, Thomas D. Dotterer, J. H. Gibbes, C. M. Scott, C. P. Ryan, Hugh Smith, W. A. Hart, J. D. Pittman, F. L. Martin, D. L. Smith, D. L. Smith, Jr., C. M. Graham, Robert Wilson, Jr., D. C. Stoudenmire, T. G. Goldsmith, W. H. Kelley, B. O. Ravenel, J. A. Wertz, M. L. Peeples, Jr., W. L. Pressley, M. J. Boggs, T. E. Ryan, E. Z. Truesdell, J. D. Guess, J. N. Gaston, William Weston, J. B. Latimer, William Weston, Jr., P. M. Kinney, L. E. Madden, F. E. Zemp, O. B. Mayer.)

It would not be difficult for a physician to give his impressions as to the general condition of the individuals in his practice. As he sees patients in his office, in the hospital, in clinics and in their own homes, he has ample opportunity to study them. Being trained to observe, he not only sees the disease or condition of the moment but appraises the patient as a whole—his physical make-up, his social background, his mentality, his financial status, and his degree of education. From these observations, he

draws conclusions which are difficult to reduce to mathematical formulae and yet which, in fact, may paint a truer picture of existing conditions than would a table of statistics. I am convinced that statistics are of extreme value in the study of disease and of nutrition but I am also convinced that they should supplement and not replace good clinical observations.

With these thoughts in mind, I was glad to accept an invitation to appear before this group to discuss the nutritional status of the people of South Carolina from a clinical standpoint.

My first plan was to present my own observations based upon eighteen years of practice among the children of Florence and of the Pee Dee section of the state, but I soon realized that such a presentation would be inadequate. In the first place, I was invited here to represent the South Carolina Medical Association and not my own practice. Secondly, my impressions would be limited to my own small group of patients and might not be representative of people of all ages from all parts of the state. So I changed my plan and decided to call upon certain of my friends for aid.

A month ago, I sent out a questionnaire to a selected group of physicians. These men were chosen because they were known to be good clinical observers. Some of them are located in larger cities, the others live in small towns or rural communities. All have large practices and all are hard workers. Among the physicians who returned the questionnaire were 36 general practitioners, 11 pediatricians, nine internists, three obstetricians, and one otolaryngologist—making a total of 60. It is my belief that these sixty physicians, representing as they do every section of the state, have had ample opportunity to study our people, and the observations which they have made and which form the basis of this paper should prove a valuable contribution to our knowledge.

Before presenting the results of the questionnaire, I would like to define certain terms so that there may be no misunderstanding. Nutrition is the process of converting food into living tissue. For an animal to be in a state of good nutrition, therefore, means that the animal is receiving and assimilating that amount of food which will result in optimum growth and development. Malnutrition or poor nutrition on the other hand, would indicate a condition resulting from inadequate intake or absorption of essential food factors. These essential food factors are not only vitamins but proteins, certain minerals, certain amino acids, certain fatty acids, and calories sufficient to produce energy.

Now to proceed to the questions and their answers.

The first question read, "Roughly speaking, what percentage of your patients show evidence of malnutrition?" The average of the answers was 19%. In other words, about one out of every five patients who consults a physician in South Carolina shows some evidence of poor nutrition.

The second question was an attempt to classify these malnourished individuals as to their age, sex, color, and financial and educational status.

Malnutrition was reported in all age groups (old age, middle age, young adults, children, and infants). The largest number was observed in children and the smallest number in young adults.

Classifying the patients as to sex, it is apparent from the observations of these sixty physicians that females in South Carolina are more prone to show malnutrition than males. On the other hand, there appears to be little difference in the number of patients when they are divided by color. Malnutrition is found in both the white and colored population. It should be borne in mind, however, that the number of white patients seen by these physicians is far out of proportion to the number of colored. If equal numbers of both races were observed the answers might have been different.

When the victims of malnutrition are divided according to their financial and educational status, the line of demarcation becomes marked. The great

majority of individuals with poor nutrition belong to the small income group and to the group who have been poorly educated. It should be noted, however, that some of them are to be found among the well educated and in the ranks of those who are comfortably fixed financially.

The third question was, "What factors are mostly lacking in the diet of your patients with poor nutrition?"

Almost every one of the sixty physicians listed the lack of proteins, iron, and vitamins as causative factors in producing malnutrition in South Carolina. A second mineral, calcium, was also implicated by over half of those answering the questionnaire. Among the vitamins found to be missing from the diet, the outstanding one was the Vitamin B Complex, as reported by 75% of the physicians. Vitamin C was mentioned by 20% and Vitamin A by 12%. A lack of Vitamin D does not appear to play any material part in the production of malnutrition in the older groups but is a prime factor in infants and small children as evidenced by the observations of those physicians who deal exclusively with young patients.

In the next question we attempted to determine the number of manifest deficiency diseases which are now being seen by practicing physicians. From the answers received we may conclude that rickets, scurvy, and pellagra are still to be found among the people of South Carolina but that they are not seen nearly so frequently as they were ten years ago. Beri-beri and keratomalacia are rarely if ever, seen.

We now come to the fifth question, "What are the bad eating habits of our people?"

I wish that I could read all of the comments submitted in response to this question since they are highly illuminating, but time will not permit. Therefore, I will present four illustrative statements and summarize the other answers.

A physician with a large rural practice in one of the poorer counties of the state writes, "The average diet of many of my patients consists of coffee and cornbread for breakfast; buttermilk, cornbread, fat back, and pinto beans for dinner; and cornbread and buttermilk for supper. It is difficult for me to get my patients to eat liver and fresh beef." A physician in a small town reports that, "the most and worst cases of malnutrition are in young women who work and make cold drinks and sandwiches take the place of a good meal." From an obstetrician in one of our larger cities comes this statement, "I am firmly convinced that humans require animal proteins in their diet. In my obstetrical practice, I have difficulty in getting my patients to eat lean meats and to drink milk, and equal difficulty in restricting the eating of starches and sugars, especially refined cereals and potatoes. This is true of all economic classes but less true in negroes in fair circumstances than in poorer white people. Possibly negroes eat more visceral organs and cheap cuts of

meat, and less fat. Mild and moderate anemia is my most prevalent abnormal finding in all types of patients." This comes from a doctor in one of our textile communities, "A man and his wife who work together in industry are more apt to have malnutrition than if the wife stays at home. This is borne out in observing the high percentage of malnutrition among textile workers whose income exceeds that obtained by the average farmer. My observation is that, as a whole, the general nutrition of farmers, even tenant farmers, is above that of the textile worker."

As I have studied the answers from all sixty physicians to this fourth question, I have been able to classify the poor eating habits of our people under six general heads.

1. Eating and drinking between meals. The habit of crackers or sandwiches accompanied by a soft drink, or of eating sweets, between meals is probably the greatest enemy of a normal, healthy appetite.

2. Failure to eat green vegetables, fruits and milk. Because of indifference, personal dislike, or sheer laziness, many of our people do not secure and eat these essential items of a good diet.

3. The tin can. Even though it is far more costly, it is far easier to open a tin can than it is to raise one's own vegetables. The man of limited means may have ample time and ample space in which to plant his own garden, but all too frequently he succumbs to the line of least resistance and feeds himself and his family scantily from the grocer's shelf rather than to feed abundantly from his own back yard.

4. Faulty cooking of vegetables. A habit, far too frequently observed, is that of boiling vegetables in a copious amount of water in an open vessel for a long time. Much of the vitamin and mineral content of the food is either destroyed or transferred to the water which is poured down the drain. The finished product when served may be tender and tasty but it has lost much of its value as a carrier of essential food factors.

5. Self prescribed reducing diets. By nature, individuals differ. And yet there are those who would attempt to make each person discard that very thing which makes him or her an individual and conform to some arbitrary, artificial standard. Nowhere is this more apparent than in the realm of women's styles.

There is no such thing as a normal weight for each person of a given height. Some people come from a lean ancestry while others have ancestors who bordered on the adipose. How can anyone expect to establish an arbitrary weight for persons with such varying heritage. But style, caring little for the laws of inheritance, decrees that every woman must present a sylph like figure or else suffer the danger of social disgrace.

Fortunately there are many women in South Carolina who are perfectly willing to let Nature take its course, but there are others—and their number is not small among the older girls and younger women—who place the mandates of style above all else. For them, success or failure is determined by the scales and the tape measure. An extra pound here or an extra inch there—and they are off on another self prescribed reducing diet.

For one who really needs to be rid of an accumulation of fat, a scientifically prepared reducing diet can be of great benefit. But for that young woman or girl in her late teens who merely wants to lose weight so that she will be in style, the reducing diet so glibly given by a friend or by some well worded newspaper advertisement or by some sugar-toned announcer on the radio, is a tragic blow at good nutrition. She may lose the desired number of pounds but at the same time she may lose her chance for buoyant health.

6. Overeating. Or as one of the physicians stated it so aptly, "Eating too darn much of the wrong foods."

Many people in South Carolina—and this faulty eating habit is not peculiar to this state—seem to think that the art of eating consists of filling the stomach to capacity three times a day. And the foods which they find most filling—and also the tastiest and easiest to secure—are bread, rice, grits, potatoes, and desserts.

One of the basic requirements of an adequate diet is a sufficient number of calories in the food. Yet not one of the sixty physicians mentioned a lack of calories in the diet as a major cause of malnutrition in South Carolina, except in the instance of those on self prescribed diets. This was not due to any oversight on the part of these physicians. From their observations they know that the vast majority of South Carolinians secure an ample supply of calories. But they also know that calories alone do not make a balanced diet. A large helping of grits or a big slice of cake may satisfy the appetite, but they do not supply the proteins, the vitamins, the minerals which the body needs.

The final question—which might be termed the sixty-four dollar question—read, "What are the greatest needs of our people in the field of nutrition?"

One would anticipate a variety of opinions in the answers received—but such was not the case. There was complete agreement among the sixty physicians questioned. With one accord, they answered—Education. These physicians know that the three greatest foes of good health in South Carolina are poverty, indifference, and ignorance—and that the greatest of these is ignorance. They also know that the only effective way to fight ignorance is through education.

Physicians are not trained in the art and science of pedagogy, but as I read the answers to this last

question I became aware of two definite principles of teaching which these sixty physicians advocated above all others, (1) teach in simple terms which even those with limited education will understand, and (2) teach the children.

During recent years there has been a nation-wide educational program in behalf of good nutrition and the need for a balanced diet. But all too frequently the effort has been to little avail because those who were privileged to hear the lesson, failed to understand. If we are to educate our people concerning good nutrition, we must talk in the simple language of the worker in the factory and the laborer on the farm. It may be scientifically correct to discuss with these individuals the need for a daily intake of proteins, vitamins, and minerals, but it is little more than useless as a source of education. The worker and the laborer must be talked to in terms of lean meat, collard greens, and pot-liquor, if he is to understand the message which we desire to convey. Less grits and more vegetables, less fat-back and more red meat, less sweets and more fruits, and a cow on every farm—this is the type of message which we must carry to our people.

To be of greatest value, the process of education must begin with our children in school. If the young boys and girls of our state can be taught the essentials of good nutrition, our next generation of adults will be far healthier than are the adults of today.

For several years I have been observing the teaching of health and hygiene in one of our state's more progressive schools and I have become convinced that the results fall far short of the goal anticipated. What is true of this school is undoubtedly true of most other schools in South Carolina. In fact, there are probably many schools where the results of this teaching are of no value whatsoever.

As I have observed, I have come to the conclusion that there are two major faults in our present system of teaching health. The first fault is that the textbooks now being used are not adapted to our needs. Written by individuals who are versed in science but who evidently know little of child psychology, they fail woefully in teaching the simple basic principles of good health. The average man has a small and large intestine—but not the fifth grader in our schools. He has a duodenum, a jejunum, an ileum, a cecum, and a colon. You and I have wax in our ears but not the sixth grader—he has cerumen in his auditory canal. Or at least he does until the examination is passed. And even the third grader—bless her little heart—cannot use sugar for her cocoa as her mother does. She has to use a carbohydrate.

How can we expect our youngsters to know and appreciate the simple fundamentals of healthful living when their brains are crammed with all this excessive and unnecessary verbiage. Is there any wonder that

the courses in hygiene and health are among the most unpopular in our entire curriculum! When will someone arise with a knowledge of children as well as of science who will give us textbooks which will teach our children the facts they should know and heed, if they are to be healthy and robust individuals.

The second great fault in our teaching of health and hygiene in public schools lies in the fact that those who teach the subject are so poorly prepared. Let us consider for a moment the average grammar school teacher. When she stands before her class to teach arithmetic, she has as her background many years of study in mathematics—from arithmetic up through algebra to geometry and perhaps trigonometry. She knows her subject and is qualified to teach. But when the arithmetic book is laid aside and the textbook of health and hygiene is pulled out of the desk, upon what foundation does she stand? She may have had one short course in college, or she may have had none at all. Her only knowledge may be that gleaned from reading the textbook which she holds in her hand. So far as I can determine, a primary grade teacher is not required to show evidence of having studied hygiene or health to be certified in this state. How can we expect such a person to be qualified to teach the subject adequately! How can she make the subject interesting if she does not depart from the words of the printed text! How can she be expected to sift the grain from the chaff if she does not know which is which!

If the educators of South Carolina want to do their part in raising the standards of nutrition in this state, they can make no greater contribution than by securing for our children textbooks worthy of the name and teachers who have adequate instruction in the field of health.

SUMMARY

In this paper I have attempted to give a picture of the nutritional status of the people of South Carolina as seen through the eyes and the experience of sixty practicing physicians. Here in brief, is a summary of what has been said:

Evidence of malnutrition is found in approximately one out of every five individuals in South Carolina who consult a physician. It is noted in about equal numbers in white and colored people. It occurs in all age groups but is slightly more evident in children. The great majority of cases are found in the low income group and among those who are poorly educated. The essential food factors which are most frequently lacking are proteins, iron, and Vitamin B Complex. Other factors which are also deficient at times are calcium, and Vitamins D, C and A.

The main bad eating habits of our people are: eating and drinking between meals; failure to eat green vegetables, fruit, and milk; relying too much upon canned foods; faulty cooking of vegetables;

self prescribed reducing diets; and overeating.

The great need of our people in the field of nutrition is education. If we are to educate our people

we must teach them in simple terms which even those of limited education will understand, and we must above all teach our children.

Congenital Malformations Following Rubella in the Mother

And Some of the Public Health Aspects*

JUNIUS W. DAVIS, JR.

From Australia in 1941 D. N. McAlister Gregg reported a series of 78 congenital cataracts in infants whose mothers had suffered from an exanthematous disease during the early stages of pregnancy diagnosed as German measles or rubella; 44 of this series of infants also showed congenital lesions of the heart. Rubella was undoubted in all but 10 of the 78 mothers and in these 10 there was no recollection of such an attack when these women were questioned in retrospect. In these 78 cases there were 15 subsequent deaths, usually associated with congenital heart lesions or prematurity; Gregg noted that many of his cases were "small in size, ill-nourished and difficult to feed." This was the first indication that maternal rubella might affect the offspring.¹

Review of the Literature

In 1943, again from Australia, Swan *et al.* extended and confirmed Gregg's observations, reporting the effects on the fetus in 49 cases of rubella, occurring in all stages of pregnancy. The 25 mothers having the disease in the first 2 months of pregnancy all without exception bore children with congenital defects. The 8 having rubella in the third month showed defects in one-half of the offspring while 16 mothers afflicted with German measles after the third months were noted to have only 2 malformed children. In this group of 49 cases of Swan's, as in those of Gregg, multiple malformations were noted in one infant. Thus there were 17 congenital cardiac lesions, 14 cases of congenital cataract, 7 deaf mutes, 1 Mongolian idiot, and several cases of microcephaly, hypospadias, and mental retardation. (3) Swan later observed and reported 13 more cases of rubella early in pregnancy with a resultant 13 congenitally deformed infants.²

Autopsies were performed on 3 of Swan's cases. In these the mothers had rubella at one and half, one, 2 and 2 months respectively. His findings revealed patent ducti arteriosi in all 3, congenital cataracts in all 3, patent foramen ovale in one, interventricular septal defect in one, enlarged hearts in all, undescend-

The Author:

Dr. Davis is a recent (1946) graduate of the Medical College of the State of S. C. During his senior year he submitted this paper in competition for the Ravenel Cup, and it was so well prepared that it was forwarded to this Journal for publication.

ed testes in one and microphthalmos in one.⁴

Recently the same connection between maternal rubella and infant anomalies has been reported by several American observers. From New York in 1944 Reese reported 3 mothers with the exanthem in the third week, fourth week and first month of pregnancy respectively, and found congenital heart defects and cataracts in all the progeny. Moreover 2 of these showed microphthalmia and one had a mild pyloric stenosis.⁵

Erickson, also in 1944, reported 11 California cases with the onset of rubella in the fourth month. These 11 infants were said to demonstrate 9 cataracts, 1 corneal opacity, 4 instances of microphthalmos and 9 congenital heart lesions and 2 were mentally retarded. He was of the opinion that the cardiac lesions were interventricular septal defects. He further states that there was no family history of eye or cardiac abnormalities in any previous offspring or relations.⁶

Rones in the same year wrote of the occurrence of cataract in 2 babies whose mothers had contracted German measles during the second month of pregnancy and another cataract in an infant whose mother had had the infection during the third month.⁷

The American-reported cases were further added to by Long and Danielson with 6 infants whose mothers had had rubella when from 2 to 6 weeks pregnant. Three of the children had bilateral cataracts which were associated with bilateral microphthalmos. All 6 had cardiac defects, septal defects being suspected in 4. There was also one case each of club foot, undescended testes, hypospadias and dacryostenosis.⁸

*Paper in competition for the Ravenel Cup.

Two additional proved cases of German measles with cataracts in both infants and a heart lesion in one are those of deRoeth and Greene. The mothers of these 2 had German measles when 5 and 7 weeks pregnant.¹⁰

Altman Dingmani report (1945) a child with unilateral congenital cataract and loss of cochlear function, the mother having had rubella in the latter half of the second month of her confinement.¹¹

Greenthal reported 2 cases in which the mother had a medical diagnosis of rubella during the first 2 months of pregnancy. One of the babies suffered deaf mutism and the other had a unilateral cataract, a heart lesion and mental and physical retardation.¹⁸

Albaugh of Los Angeles has recently written of 6 additional instances of cataract in the offspring following maternal rubella, as well as cataracts in the offspring of 2 mothers who had measles (morbilli) during early pregnancy.¹²

Perera this year from New York adds 2 more cases with unilateral cataracts and congenital heart lesions, "probably patent ductus," whose mothers had rubella in the second month of gestation.⁹

Thus available data would suggest that 100 per cent of the mothers who contract rubella in the first 2 months of pregnancy and approximately 50 per cent of those who contract it during the third month will give birth to infants with congenital abnormalities or malformations.

Embryology and Pathology

In an embryo of 6 weeks (10 mm.) the heart exhibits the general external shape and markings that characterize it permanently. At this time torsion of the great vessels is taking place and in the seventh week in utero the interventricular septum is formed. This is about the last major structural developmental change to take place in the embryonic heart since the foramen ovale does not close until after birth. Important changes in the lens vesicle are also becoming manifest from the fifth and a half to the seventh week. Thus it would seem that rubella in the mother at this time is indeed occurring at a critical time in fetal life.^{13 15}

Swan's 3 autopsies on infants with congenital defects coincident with maternal rubella reveal in all 3 widely patent ductus arteriosus and one had a patent interventricular septum. The precise method of closure of the ductus arteriosus has been a matter of considerable speculation. Swan inferred that the etiological agent of rubella had produced some structural alternation in the wall of the ductus which prevented its closure.⁴

On clinical grounds Gregg states that the type of cataract was apparently a new entity and did not "exactly . . . correspond to any of the large number

of morphological and developmental lenticular opacities that have been described."¹ The post-mortem histological examination by Swan fully confirmed this finding. He stated further, "Whatever the pathological process may be, it is evident that it had led to necrosis *en masse* of the nuclear portion of the lens. The degeneration probably results from the prolongation of action of the etiological agent for some time after its initial attack upon the lens." He noted further changes of vascular tissue throughout the body, including glomerular sclerosis.⁴ The presence of the rubella virus in differentiating embryonic tissue, then, would not be inconceivable, and, indeed, the changes noted could be ascribed to its intra-nuclear implantation.

Swan, of course, was not contending that all congenital malformations are due to virus infections in utero. There is some clinical and ample experimental evidence that vitamin deficiency, endocrine disturbances, and toxic influences, as for instance, irradiation of the pregnant uterus or feeding a mother animal naphthalene, can produce cataract in the fetus.¹⁰ But it is natural to assume that the viruses, being smaller, may pass the barrier of chorionic villi with more ease than larger bacteria. It is a known fact and one that is utilized in virus culture work that chick and other embryonic tissue is relatively highly susceptible to virus infections.⁴ This may also explain the apparent contradiction that even though the mother may not appear seriously or even noticeably ill, grave injuries are becoming manifest in the fetus.

Possibly the more severe virus infections such as true morbilla may kill the fetus and cause an abortion while rubella merely injures the germ plasm and produces malformations.

Epidemiology

It is of course highly improbable that in the diagnosis of all of the 163 cases reviewed above there could be significantly large numbers of mistaken diagnoses. But why, if the incidence of congenital anomalies was so high, had the relationship to rubella never been noted before 1941? It would seem that the best explanation is that the virus in the epidemics in Australia had become more virulent or in some way altered. The 1940 epidemic in the "down under" continent was adjudged by all observers to be a severe one, which for the most part affected young persons who had not been exposed in previous epidemics. Complications were frequent.⁵ The description of the disease was pleomorphic however, and the diagnosis in some instances was questioned since there was a concurrent epidemic of streptococcal sore throat in many of that country's military installations. But in a decided majority of the cases there was no doubt that the outbreak was one of rubella.^{3 4} It is also quite probable that the virus, having been thus altered or having undergone some subtle change, would easily have spread to this country and could

have accounted for the many cases of the combination of rubella and fetal anomalies still being widely reported in our national medical periodicals.

There was, as everyone knows, greatly increased traffic with Australia throughout the war years and some of our first cases were reported from California, Colorado, Arizona and other western states.

Lynch found that in the more serious disorder rubella the fetus rarely survived the infection in the mother. He also showed that in 47 cases of fetal smallpox there was a mortality rate of 80 per cent.¹⁷ This would seem to indicate that the critical factor in rubella is not that the virus has become more virulent but that the infection occurs when the fetus is particularly vulnerable; when highly important embryonic changes are taking place. The severe attack upon the fetus, however, may have been made possible through some undiscovered viral alteration such as its occurrence concomitantly with streptococcal infection. Even though this is mere speculation, further research along these lines should be undertaken.

Public Health Aspects

Whether the disease is rubella and whether to accept the association with fetal changes has not developed into a rather raging controversy with one extreme being that forwarded by Rones⁷: "Many thousand more cases will need to be compiled before these findings are accepted as fact rather than coincidence." He wisely suggests that some national agency be empowered to carry out statistical studies to establish the validity of present assumptions. The other extreme are those, including especially the Australians, who merely, and at times somewhat blandly, state that they firmly believe the injuries to be the result of maternal rubella. Dr. Ira Mann believes that this association has long been present but has not been recognized in the past.¹⁴ Dr. Philip Stimson of New York states that he has yet to hear of an authentic case of rubella in early pregnancy without fetal anomalies.¹⁶ At any rate, the causative agent of rubella, previously considered innocuous, should now be tackled vigorously by those engaged in virus research. If the causative agent could be isolated and a protective vaccine prepared, we would have a plausible method to protect pregnant women who are exposed to rubella or who become pregnant during epidemics.

At the present time, it would appear logical to prohibit girls from passing through childhood without having German measles—"a deliberate exposure at an opportune time would seem wise"—though, to be sure, the complications are not without danger. Still, the risks of complications are probably no greater than with vaccination for smallpox.¹⁴

Erickson has suggested that convalescent serum might be used for all women early in pregnancy that have not had rubella.⁶ That this might prove effective

is shown by the work of Barenburg *et al.* who had no secondary cases of rubella, and a reduction in the number of primary cases, in pediatric wards in which all patients were injected with 30 cc. of pooled human serum or plasma, both during and between epidemics and including the severe outbreak of German measles in New York in 1940-41.¹⁵ Swan further suggests that the use of convalescent serum be studied both for its effect during the incubation period and as a prophylactic for nonimmune pregnant women.⁴ Albaugh reminds us that this is not altogether practicable since convalescent serum is difficult to obtain except in the larger centers, and, since "in many instances women do not realize they are pregnant until after the first month and sometimes much later," it might not be altogether useful.¹²

The question of abortion in women having rubella in the first trimester has been considered but because of the lack of legal precedent, not to mention legal sanction and religious scruples, this has been advocated by only a few.⁸

The possibility of producing similar malformations in experimental animals using different viruses and extending throughout the entire period of gestation would seem to offer great promise in advancing our knowledge in this field and would decidedly help in determining whether legal sanction to perform such therapeutic abortions should be granted and whether the physician would be morally justified when the diagnosis of rubella is made without complete certainty and when the life of the mother is not at stake.

Ophthalmologists agree that operation for cataract should be performed practically immediately on these infants because early needling permits sufficient light to reach the retina in order that fixation may be developed. "If the stimulus is insufficient or delayed, nystagmus will result."⁸ Gregg¹ and Swan⁴ advocate "break-up" of the whole cataract and Albaugh¹² recommends the suction method of operation for these cataracts. And yet it is too early in the unfolding of this remarkable disease-anomaly relationship to evaluate the long-range effect of surgery on the vision of these children. It should be remembered that congenital heart defects will in many of these patients be a possible contra-indication to, or complicating factor in, general anesthesia.⁷

Of course, it goes without saying that now that German measles, in the past considered to be practically void of complications, should now be isolated more strictly, particularly when there is possible contact with a previously-uninfected pregnant woman.

Another important public health aspect is the information and education of the general public concerning these new-found though not completely accepted concepts. *Time Magazine* has already carried an article in their "Medicine" section that was straightforward and informative.¹⁶ Mothers are be-

ginning to realize the potential dangers to the happiness of their daughters who are now reaching puberty and have not had German measles. Young married women should be made to realize the importance of avoiding the disease (early in pregnancy particularly) and some are already asking the advice of their physicians on the ways and means of anti-rubella prophylaxis. Furthermore parents who have had congenitally malformed infants now recall in retrospect that the mother *did* have rubella early in her confinement and can now be reassured that further progeny will not be malformed as they might have feared.¹²

Summary

(1) Reports of 163 instances of congenitally malformed infants whose mothers had rubella (German measles) early in pregnancy are reviewed.

(2) Available data would suggest that 100 per cent. of mothers contracting rubella in the first 2 months of pregnancy and 50 per cent of those contracting it in the third month will have congenitally malformed babies, cataracts and heart lesions being the most conspicuous anomalies.

(3) The possibility that the virus of rubella has been in some way altered since 1941's severe epidemics in Australia and the United States must be considered.

(4) Attempts should be made to isolate the specific causative agent or rubella with the object of preparing a protective vaccine against the disease.

(5) Young girls should be deliberately exposed to rubella.

(6) Pregnant women should be rigidly protected from exposure to cases of rubella.

(7) Convalescent serum should be given to all pregnant women during epidemics and after exposure.

(8) Therapeutic abortion can be considered.

(9) The present campaign to educate and inform the public about this disease-anomaly relationship should be continued and intensified.

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C. J. Scurry ----- Greenwood

R. M. Pollitzer ----- Greenville
W. J. Henry ----- Chester
W. R. Mead ----- Florence

J. J. Chandler ----- Sumter
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BUSINESS MGR.: Mrs. C. G. Watson

105 W. Cheves St. Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Florence, S. C.

Subscription Price

\$3.00 per Year

JULY, 1946

POSTGRADUATE SEMINAR

The annual Postgraduate Seminar of the Alumni Association will be held in Charleston, December 3, 4, and 5, instead of early in November as previously announced. The program of the meeting with a list of the speakers will be published later.

MEDICAL CARE FOR VETERANS

The state committee on the care of veterans has received notification from the Veterans' Administration in Washington that the contract covering this work has been signed by the Hospital Benefit Association of South Carolina as agents for the State Association, and that the fee schedule submitted is acceptable. We are now in a position to ask those members of the State Association who are interested in this work to send in their application to the Hospital Benefit Association of South Carolina at 9 South Main Street, Greenville, South Carolina. In bringing this matter to a successful conclusion we would like to emphasize that those veterans must have *service connected disabilities* and *authorization* from the Veterans' Administration for their medical care. These are essential requirements before the doctors can expect to collect any fee from the Veterans' Administration. The veteran, to get an authorization from the Veterans' Administration, should apply to his own county service officer or direct to the Veterans' Administration in Columbia, South Carolina.

It is hoped that the majority of the members of the State Association will enter into this work because we feel it is an opening wedge in combatting regimentation. A copy of this contract and the fee schedule will be mailed to each member of the State Association within the very near future. We ask that you read this and be fully cognizant of all its requirements. We urge you that in reporting these cases you keep good and thorough records, and in submitting your reports to the Hospital Benefit Association of South Carolina that they be clear, concise, and legible. We urge further that a copy of all the records be maintained in your own office. Until such a time as the Veterans' Administration

adopts a standard form for the reports it will be necessary for you to make them in as clear and as brief a form as possible for conciseness.

All doctors who wish to participate are required to register or make contract with the Hospital Benefit Association of South Carolina by submitting postal card contract as illustrated below. In the event that this postal form originates with the doctor, he is requested to leave a full 3/4 inch margin at the top of the message side of the postal card.

"I agree to comply with the Veterans' Administration contract with the Hospital Benefit Association of South Carolina for the purpose of providing medical care for beneficiaries of the Veterans' Administration."

Date

Signature

Type:

(Last Name) (First Name) (Initial)

(Street Address)

(City)

In summarizing the following procedure will be carried out:

1. The veteran secures an application form for service from the Veterans' Administration (local, State or district office) and submits completed form to the Veterans' Administration's office at Columbia, S. C. In emergency authorization might be secured by telephone to the medical officer of the Columbia office.
2. Veterans' Administration issues authorization to Hospital Benefit Association.
3. Hospital Benefit notifies veteran of the authorization and instructs the veteran to submit the approval to the registered doctor of his choice.
4. The registered doctor provides the authorized service and submits report and bill with qualifying "fee schedule number" to Hospital Benefit.
5. Hospital Benefit pays doctor and submits service report and bill to the Veterans' Administration

for reimbursement.

The actual practice of this service to the veteran will bring about amendments to the above procedure. Forms to keep the details as simple as possible will be designed from experience.

A WORD OF THANKS

Dr. Julian P. Price
Secretary, South Carolina State Medical Association
105 W. Cheves Street
Florence, South Carolina
Dear Dr. Price:

For practical purposes the functions of the Procurement and Assignment Service have been terminated and the activities of the several State offices brought to a close. The success of the program in meeting the needs of the armed forces without sacrificing the civilian population may be attributed directly to the patient and tireless devotion of many State Committees and countless local advisers. Many of these Committeemen and advisers are unknown to the Directing Board, except through the results of their efforts, and it would obviously not be practicable to communicate with them.

In a recent letter to each State Chairman, I asked that the appreciation of the Directing Board be conveyed to all the State and local representatives whose full cooperation was essential to the ultimate achievement. The Directing Board, at its final meeting on May 17, 1946, resolved that the untiring efforts, kind tolerance, and successful accomplishment of these State Committee members and local advisers be commended to the appropriate professional State Society for suitable recognition by the Society.

I hope you will draw this recommendation to the attention of your Society, and that they will be disposed to afford some such recognition.

Sincerely yours,
Frank H. Lahey, M.D.,
Chairman, Directing Board

MEMORIAL RESOLUTIONS ON

ROBERT WILSON, M.D.

August 23, 1867 — May 20, 1946

Robert Wilson, M.D., in the flesh is no more, but the spirit of Robert Wilson lives on in the hearts and lives of unnumbered men and women who knew him. His life is commended to the emulation of the present members of this Society and the future members of the medical profession in this State.

Robert Wilson was born August 23, 1867, in Statesburg, South Carolina, the son of Rev. Robert Wilson, M.D., a Confederate veteran, and Ann Jane Shand Wilson. He died May 20, 1946, in Charleston, South Carolina. His father was a physician also but never practiced this profession, preferring to enter the

ministry of the Protestant Episcopal Church. Robert Wilson received his education in private schools, the College of Charleston, and the University of South Carolina (known as the South Carolina College when he was a student there). He graduated from the Medical College of the State of South Carolina in 1892.

During his lifetime Robert Wilson accomplished more for medical education in South Carolina than any other man ever had in its history. From its organization, the College had existed as a private institution. He was responsible for its being taken over by the State in 1913. Through his guidance after he became Dean, the College was brought up to the high standard it enjoyed at the time he was made Dean Emeritus. Robert Wilson never lost his interest in the Medical College and its expansion, although he did bitterly oppose some of the present day trends.

Robert Wilson, M.D., began his teaching career in medicine as an Instructor in Bacteriology in the Medical College of the State of South Carolina and continued in this capacity until 1900. He was adjunct Professor of Medicine from 1901 to 1903. In 1904 he was elected Professor of Medicine, and Dean in 1908, resigning in 1943, at which time he became Dean Emeritus and a special lecturer on Medical History. By his example he inculcated in the medical students the correct principles by which a man should guide his life. His connection with Roper Hospital was long and valuable, and for many years he served as Physician-in-Chief on the staff of the Hospital.

Robert Wilson was a Fellow of the American College of Physicians, a member of the American Medical Association (and an Ex-Vice-President), an Ex-President of the Medical Society of South Carolina, the Southern Medical Association, the South Carolina Medical Association and the Tri-State Medical Association of the Carolinas and Virginia; also a member of the American Society of Tropical Medicine, the National Association for the Study of Tuberculosis, and the Climatological and Clinical Association. He served as Chairman of the State Board of Health for many years. He was a member and organizer of the Medical History Club of Charleston. He was appointed a member of the District Exemption Board for the Eastern Federal District and served during World War One.

Robert Wilson was always active in community affairs, notable among them being the Charleston Museum, he having served as Vice-Chairman and, in recent years, as Chairman of the Board of Trustees of this Institution.

Robert Wilson, M.D., was made a Mason at sight, his membership being in Orange Lodge No. 14, Ancient and Accepted Free Masons. He was a member of the St. Andrew's Society, the Sigma Alpha

Epsilon Fraternity and the Phi Chi Medical Fraternity. In his religious faith he was an Episcopalian, being a member of St. Michael's Protestant Episcopal Church in Charleston, South Carolina.

In 1895 he married Miss Harriet Chisolm Cain, of Pinopolis, South Carolina. He is survived by his wife, two sons and a daughter.

Many honors were conferred on Robert Wilson. The honorary degree of LL.D. was twice given him, first in 1918 by the University of South Carolina, and second in 1922 by the College of Charleston. In 1926 the University of the South at Sewanee, Tennessee, conferred the honorary degree of Doctor of Civil Laws. The American Legion of the State presented him with a plaque as the man in South Carolina who had contributed the most distinguished service to the State in the year 1939.

When people in all walks of life shed tears at the passing of a man in the Year of our Lord 1946, we realize that a greatly beloved and valued man has passed our way. Robert Wilson was a cultured man, one who traveled extensively, yet he was modest in his contacts with his fellowmen; a widely read man, yet one ever ready to discuss with friends and patients the ordinary things that come into the lives of men and women, some of whom were not so well situated; untiring in his efforts to alleviate suffering whenever and wherever he found it, how can man evaluate his worth? This evaluation may

safely be left to posterity.

As Paul wrote in his Epistle to the Romans, "For none of us liveth to himself, and no man dieth to himself." To those of us who remain, Robert Wilson left a legacy far more valuable than silver, gold or precious stones, and, if we accept this legacy and cultivate in our own lives the qualities of mind and heart possessed by him, it will soften the ingratitude that men sometimes meet with in their lives.

THEREFORE, Be It Resolved:

1. That the death of Robert Wilson, M.D., leaves the medical profession richer because of his having lived among us;

2. That his interest in the growth of his beloved City, State and Country was shown in his unflagging zeal in their behalf;

3. That the Medical Society of South Carolina grieves over the departure of a true friend and valued member, and desires to record the honor he brought to it as a member.

and

4. That a page in the Minute Book of the Society be inscribed to his memory, and a copy of these Preamble and Resolutions be sent to his family.

(Signed) R. S. Cathcart, M.D.

G. McF. Mood, M.D.

F. B. Johnson, M.D.

June 11th, 1946.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE TAFT HEALTH BILL

Designed to coordinate the health activities of the Federal Government in a single agency and as a substitute for the far-reaching provisions of the Wagner-Murray-Dingell Bills, the proposed "National Health Act of 1946" was introduced in the United States Senate on May 3 by Senator Taft, for himself and Senators Smith and Ball, and was referred to the Committee on Education and Labor. It is this committee, Senator Murray chairman, before which the public hearings on S. 1606 (The Wagner-Murray-Dingell Bill) are being held.

The Taft Bill (S.2143), in its preamble, takes note of the fact that national health functions are widely scattered among many agencies of the Federal Government, with resultant confusion and duplication of effort, that there are inadequacies in the distribution of services pertaining to health in the country, and outlines the policy of the United States to aid the states through consultative services and grants-in-aid for extension of health services to every individual, regardless of race and economic status,

and the further policy to provide for voluntary deductions from the salaries of federal employees of premiums to voluntary non-profit health insurance funds.

Title I: National Health Agency

One of the most constructive efforts yet made in the direction of improvement of government health activities, is the provision in Title I of this bill creating in the Executive Branch of the government, an independent division to be known as the National Health Agency, headed by a National Health Administrator, to be appointed by the President, with the advice and consent of the Senate, with a salary fixed at \$15,000.00 per year. The Administrator must be a doctor of medicine, either with at least 8 years experience in the Commissioned Corps of the Public Health Service, or licensed to practice medicine or surgery in at least one of the states, and having had not less than 5 years active practice and 3 years experience in a responsible position in medical research, teaching or administration.

The purpose of the Agency would be to promote the general welfare of the people by aiding and fostering programs in the field of health, and centralizing the health activities of the Federal Government. It would be the duty of the Agency to carry out this purpose by encouraging the development of health services and facilities throughout the nation; advising and cooperating with other agencies and departments, government and private, likewise engaged; collecting and analyzing statistics; making studies and reports on conditions, problems and needs in the field of health; recommending policies and legislation to carry out desired methods for promotion of health, and by performing such other duties as might be delegated to it, including general supervision of the existing agencies to be transferred.

The National Health Agency would be responsible for government activities concerned with funds appropriated as grants to the states for medical and dental care, hospitals, and in the various health activities; prevention of diseases through water purification, sewage treatment and elimination of stream pollution; promotion of maternal, infant and child care; and promotion of purity, standard potency and correct labeling of foods, drugs and cosmetics. Also, the training and rehabilitation of persons vocationally handicapped, and such related matters as would aid the states and the people of the nation in maintaining adequate and efficient health facilities. The Bill would not, however, transfer to the Agency or otherwise affect any of the duties or authority now vested in the Army, Navy or Veterans' Administration.

The following existing agencies and services would be transferred to the National Health Agency: The Public Health Service, St. Elizabeth's Hospital, the Food and Drug Administration, and the Office of Vocational Rehabilitation; also the functions of the Children's Bureau in the Department of Labor concerned with the administration of Title V, Parts 1 and 2, of the Social Security Act, and the functions of the Social Security Board relating to health studies and statistics. Due provision is made for the transfer and retention for the same use for which they were designed, of the funds of the various agencies to be transferred, the protection of personnel now employed in those agencies, and the effectiveness of orders, regulations and proceedings with which any of such agencies are now concerned. Provision is also made for further study of the activities of other departments of the government, to ascertain if additional duties and functions should be transferred to the same Agency.

The National Health Agency set up under the proposed law, would be composed of several constituent units, to wit: the Office of the Administrator, the Public Health Service, the Food and Drug Administration, Office of Vocational Rehabilitation, Office of Maternal and Child Health, Office of Health Statistics, and such other constituent units as the

Administrator finds necessary. The Public Health Service would assume administration of St. Elizabeth's Hospital and Freedmen's Hospital. Organization of this branch, the Food and Drug Administration, and the Office of Vocational Rehabilitation would remain unchanged, except as changes were necessary to conform to the proposed bill. The Surgeon General would continue to be appointed as now provided. The heads of the other constituent units would be appointed henceforth by the National Health Administrator. In his absence, or in event of a vacancy in his office, the Surgeon General would act as Administrator and while he is engaged in that capacity, the Deputy Surgeon General would act as Surgeon General.

Within the office of Maternal and Child Health Care, provision is made for an advisory council on maternal and child care, to be appointed by the Administrator, composed of eight members, at least three of whom would be doctors of medicine who are specialists in Pediatrics or Obstetrics. The duties of the Council would be to advise and consult with the head of this branch of the Agency. Each member would hold office for a term of four years, with expiration dates so arranged that the terms of only two would expire each year. The Chairman of this group would be named by the Administrator and the members would be paid a per diem to be fixed by him, not in excess of \$25.00, together with actual and necessary travelling and subsistence expenses. Such expenditures as are necessary to provide office space, furnishings and related necessities are authorized to be made by the Administrator, who would report to Congress at the close of the fiscal year, accounting for all monies received and making recommendations with respect to effective performance of the work of the agency. Appropriation of funds for administrative expenses is authorized and this Title is designed to take effect July 1, 1946.

Title II: Grants-in-Aid for Medical and Dental Services: Research

Title II of the bill contains amendments to the Public Health Service Act, designed to place the Public Health Service under the National Health Agency and the National Health Administrator instead of the Federal Security Agency and the Federal Security Administrator, as at present. Appropriation is made for research, demonstration and training in general medical health by grants-in-aid through the National Institute of Health, to universities and similar institutions, of \$2,000,000 a year for the next 5 fiscal years, and for medical research in and operation of the National Institute of Health, \$2,500,000 annually. The bill would amend the Public Health Service Act further by adding several new Titles containing the provisions indicated below:

Medical Services: General medical service for families and individuals with low income would be provided through a system of grants-in-aid to the

various states upon the basis of plans to be submitted by the states and approved by the Surgeon General, and which in order to obtain such approval, must fulfill certain requirements set up in the proposed new Title VII. Appropriation of a total of \$1,000,000,000 is authorized to be used over a period of 5 years, in equal amounts, for this purpose. Congress is directed to review the program and determine the amount to be authorized after expiration of that period.

Any state plan, to secure approval, must designate a single state agency for its administration within the state, and after 1948 the agency shall be the state health agency. The plan must also provide for a health advisory council within the state, to include representatives of non-government organizations and state agencies concerned with matters of health, medical and hospital services, representatives of the medical association and of voluntary non-profit medical and hospital associations and other groups similarly interested. The plan must contain satisfactory evidence that the agency so designated will have authority to carry out the same in conformity with the Federal law and especially, must set forth a state-wide program designed and calculated to provide within five years hospital, surgical and medical services in hospitals, clinics and similar institutions, for all families and individuals with insufficient income to pay the whole cost of the same, and also health inspection services for all children in elementary or secondary schools in the state. Provision also may be included for medical care in the home or physician's offices, and for furnishing such services to such families and individuals by means of payment or part-payment by the State, of premiums to any voluntary health, medical or hospital insurance fund not operated for profit. The plan must provide for collection of part of the cost from those beneficiaries able to make part payments in line with their ability to pay. The State plan would be based on a state-wide inventory of existing available medical and related care, provided by the State and by private organizations; would take into account services rendered by governmental subdivisions and private organizations, and would provide for payment to such institutions for the care rendered the beneficiaries under the plan. It might also include provision for annual payments to physicians practicing in areas which otherwise would be unable to provide sufficient income to attract a practicing physician. The state plan would be required to describe in detail the services contemplated, in order to insure that the same would be furnished without discrimination because of race, creed or color, to all persons unable to pay for the same.

In order to participate, a State would have to provide twice the amount of the grant from the Federal Government, and the plan would be required to set forth the relative need of the various projects, the method of administration, including

maintenance of personnel standards on a merit basis, provide for the making of reports to the Surgeon General from time to time, and to assure the Surgeon General access to the records of the State agency upon demand. The plan, after adoption, might be reviewed by the State agency, and modifications recommended to the Surgeon General.

In the event of the failure of the Surgeon General to approve any plan or modification fulfilling the requirements outlined above, a hearing would be granted the State agency by the National Health Council, which would have the right thereafter to direct the action of the Surgeon General. The primary goal of each plan must be a program designed and calculated by the end of a 5-year period, to provide the hospital and medical services referred to and health inspection for all children in the elementary and secondary schools, at a cost within the probable financial resources of the state, with Federal aid. As to how this goal would be attained, it is intended that the State devise the methods.

The amount which any State would be entitled to receive from the Federal government under this plan would be determined by an allotment, based on the population and "percentage of tax-paying ability" of the state, and would be directly related to the ratio of the per capita income of the State to that of the continental United States.

The measure contains further provision for the protection, safe-guard and equitable distribution of funds, for yearly reports by the States to the Surgeon General of the activities in this field and the manner in which the funds provided by the Federal government have been expended. In the event the Surgeon General finds that the State agency is not complying substantially with the provisions of the approved plan, that Federal funds have been diverted from the purposes for which they were intended, or that the State or its agencies have failed to provide their share, the Surgeon General is authorized with the approval of the Administrator, to notify the Secretary of the Treasury and the State agency, to withhold further certification for funds.

In case any state is dissatisfied with the action of the Surgeon General under the foregoing, provision is made for appeal by the State to the United States Circuit Court of Appeals for the Circuit in which the state is located. Thereupon, the Surgeon General would certify and file with the Court a transcript of the record on which his action was based. Findings of fact by the Surgeon General, unless substantially contrary to the weight of the evidence, would be conclusive, but he might be required by the Court to take further evidence, which would likewise be certified with his findings thereon, to the court. The Court would have jurisdiction to affirm or set aside the action of the Surgeon General in whole or in part, and its judgment would be subject to review by the Supreme Court of the United States in the usual manner.

Must
INCREASED IRRITATION
follow
INCREASED SMOKING?

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60; *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.



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TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

The National Health Council, referred to above, would consist of the Surgeon General, ex officio, who would serve as chairman, and eight members appointed by the National Health Administrator. Five of these members would be persons "outstanding in fields pertaining to health activities" and at least three of these must be doctors of medicine. The remaining three of the eight must be persons familiar with the needs for medical care in urban and rural areas. The term of each member would be four years, the term of two expiring each year, and the members would not be eligible to serve continuously for more than two terms. The Council could appoint such special and technical committees as it might find useful.

The Surgeon General would be authorized to make such administrative regulations as he should find necessary and in administering the Title as directed, to consult with the National Health Council; and he would be authorized to use the services and facilities of any executive department or agency, pursuant to agreement with the head of the same. He might also call conferences of representatives of the various State health agencies but except as specifically provided, the provisions of the bill do not confer on any Federal official or employee the right to exercise any supervision or control with respect to the operation of the health services of any State for which funds have been provided by the Federal government.

Dental Services: By way of further amendment of the Public Health Service Act, the bill would add a new Title (VIII) on Dental Health Services for school children and families and individuals with low income.

The aim of this part of the bill is to provide dental inspection for school children and necessary dental care for those school children, individuals and families unable to pay the whole cost of such care. The total sum of \$76,000,000 to be spent in the next five fiscal years is authorized, to be expended in making payments to states which have submitted and had approved state plans to effectuate the purposes of the title.

There is one point of difference between the provision made for dental services and that for health services. State plans are required only to provide for inspection and care of the teeth of children. Provision must be made for the inspection annually of the teeth of all children in the elementary and secondary grades in the public and private schools, and for the treatment of such of these children whose income or the income of whose parents or guardians, is insufficient to pay for the whole cost of such services.

There is no requirement that the State plan provide for the care or treatment of the teeth of adults in the low income group but the plan may do so

at the option of the State. It will be recalled that medical, surgical, and related services for all the low income group, adults as well as children, are required to be included in the provisions of the state plans.

With the above exception, the requirements to be met by the State plans for dental care and those for medical and hospital care are almost identical, the provisions for administration of the two titles are the same and with very few exceptions the language employed is the same. Provision is made for a National Dental Health Council, membership of which would consist of seven, including the Surgeon General, the Assistant Surgeon General (Dental), and five members appointed by the Administrator, at least three of whom would be Doctors of Dental Surgery. The members of this council would serve for three-year terms, expiring in alternate years. The same limitation on the length of service is provided with respect to members of this Council as to the members of the National Health Council.

Research and Training: This subject is covered by a proposed Title IX, to be added by way of amendment to the Public Health Service Act under provisions of the bill under consideration.

Part A of this Title would establish the National Institute of Dental Research, as a division in the National Institute of Health and Part B would establish a similar division to be known as the National Institute of Neuro-psychiatric Research. Part B likewise provides for the creation of a National Advisory Council on mental research, similar to the National Health and Dental Councils. This council on Mental Research would consist of the Surgeon General, ex officio, as Chairman, and 6 other members to be appointed by him, with the approval of the "administration." (The last word in the preceding sentence is quoted from the bill. Apparently this is an error and is intended to refer to the Administrator.) The six appointed members would be selected from leading medical or scientific authorities, outstanding in the study and treatment of mental or neuro-psychiatric disorders, three of whom would be doctors of medicine and the others thoroughly familiar with the problems and conditions incident to the subject. Term of office of each would be three years, expiring alternately, and the members would be paid a per diem and actual expenses, as in the case of members of the other Councils referred to in the bill.

The provisions of this title set forth in almost identical language the functions of the Institutes of dental research and of neuropsychiatric research, respectively. These divisions would be charged with the duties, in cooperation with their respective Councils, to conduct and foster research and demonstrations related to the cause, treatment and prevention of diseases in their respective fields; to promote coordination of research by the Institutes with similar research conducted by other public and private

agencies, and to make grants-in-aid to carry out the purpose of the title: to provide scholarships and fellowships in these Institutes and in other institutions receiving grants-in-aid, as may be deemed necessary by the Surgeon General, to secure necessary assistance and to train others to engage in the research work contemplated. These activities would be carried out by the Surgeon General, acting through the respective Institutes. The respective national advisory councils on these matters are authorized, in cooperation with the Surgeon General, to review research projects and programs which properly come to the attention of the council and certify approval to the Surgeon General where it appears that such projects will make valuable contributions to the store of knowledge with respect to the subjects with which they are concerned: to collect information and make the same available, on studies being made throughout the world in regard to these subjects so that doctors concerned with them, and the public generally, may have the benefit of such information; to review applications from any university, hospital or other institution, public or private, for grants-in-aid for research projects and certify such as show promise of making valuable contribution to human knowledge: to recommend to the Surgeon General for acceptance, conditional gifts, and otherwise with respect to carrying out the objects of the title. Upon such recommendation with respect to conditional gifts, the Surgeon General is authorized to make like recommendation to the Administrator, and donations of \$50,000 or more in either department are authorized to be acknowledged as suitable memorials to the donor.

Authorization of appropriation for the conduct of the research work in each division is also included in the bill, a total of \$650,000 being authorized in connection with dental research for the 2 fiscal years ending June 30, 1948, and \$600,000 for subsequent years; and the sum of \$1,450,000 being authorized in connection with neuro-psychiatric research for the next two fiscal years, and \$1,200,000 for such work thereafter.

Part C of Title IX authorizes appropriations of \$1,000,000 for erection and equipment of suitable building and other facilities for the use of the National Institute of Dental Research and \$4,500,000 for similar facilities for the use of the National Institute of Neuro-psychiatric research. The Administrator is authorized to acquire suitable and adequate sites in or near the District of Columbia for such facilities.

Title III: Miscellaneous

The remaining brief portions of the bill provide for necessary amendments of the Public Health Service Act in other particulars, to make the numbers of the titles and sections conform, and to substitute the National Health Agency and National Health Administrator or Surgeon General for the Federal Security Agency and the Federal Security Administrator,

and to make certain transfers of the functions accordingly.

Finally, it is provided that upon direction of any employee or officer of the U. S. Government, there shall be deducted from the salary of such employee or officer a fixed sum or percentage to be paid to a private or public health fund, and the latter is defined to include any non-profit organization undertaking to insure persons against the expense of hospital, medical, dental or other services connected with health.

DR. PRICE TO ADDRESS PRESIDENTS' CONFERENCE IN SAN FRANCISCO

Dr. Julian Price has been requested to address the conference of Presidents of state medical associations, at the meeting to be held in conjunction with the annual convention of the American Medical Association in San Francisco in July. According to the formal program of the conference, which was received this week, Dr. Price will address the meeting on the subject, "Why Have a Conference of Presidents?"

This is the second meeting of the Conference of Presidents and other officers of state associations. The first was held in Chicago on the eve of the meeting of the House of Delegates of the AMA last December. Organized through their efforts and sponsored by the medical societies of Michigan and California, the first meeting was marked by splendid addresses and a down-to-earth, practical and straightforward discussion of the problems of the medical profession and the methods for dealing with them. A permanent organization was set up at that time and the San Francisco meeting is the next step in the development of what should be a very valuable adjunct to the cause of organized medicine in the United States.

Dr. Price was a member of the nominating committee for the election of the officers of the organization for the current year. That fact, and his invitation to address the conference at the San Francisco meeting, are honors worthy of recognition, particularly when accorded the secretary of a state no larger in population or association membership than is South Carolina. The meeting of the conference will be held on Sunday, June 30, at the Sir Francis Drake Hotel.

Word has just been received (since the above was written) that another of the speakers on the same program will be Upton Close, world-famed analyst and radio commentator. He will present the viewpoint of his profession and the press generally, concerning current trends in the economics of medicine.

MATERNAL AND CHILD WELFARE BILL UNDER CONSIDERATION

On June 15th, Senator Pepper announced that hearings would be held by the full Senate Committee

on Education and Labor, beginning June 22, on his bill (S.1318) to provide maternal and child health services. This proposed measure was outlined in a previous issue of the Journal shortly after its introduction last July.

The provisions of the bill are included in one section of the National Health Bill, subsequently introduced and on which hearings have been in progress before the same Committee for several months.

Reports emanating from Washington for some time have indicated that proponents of the National Health (Wagner-Murray-Dingell) bill have encountered serious opposition and that the bill probably would not come out of the Committee with a favorable report at any time in the near future. The announcement of Senator Pepper of his intention to call up the previously introduced Maternal and Child Welfare Bill lends further support to this idea. It may be that the proponents of political medicine, finding

themselves unable to force the entire program down the throats of the American people in one dose, are changing their tactics and will attempt to have it swallowed piecemeal.

We were notified of the Senator's announcement immediately by Dr. Joseph Lawrence, who is in charge of the Washington office of the AMA. Senator Olin D. Johnston of South Carolina is a member of the Committee before which the committee hearings are pending.

No thoughtful person, certainly no doctor, would oppose the extension of needed medical services to expectant mothers and their infant children on any practical basis. The most startling provision of the bill referred to, however, is that its terms specifically require that the benefits provided under the bill shall be available to every mother and child. There is no effort to limit the services to those in financial need of government assistance.

NEWS ITEMS

Dr. and Mrs. John Holler of Columbia announce the birth of a daughter on May 20, 1946.

Dr. Ben F. Wyman, State Health Officer, has been named Chairman of the Hospital Advisory Council to the State Research Planning and Development Board. George W. Holman of Rock Hill, member of the State Hospital Association, is Vice-Chairman. Representatives on the Council from the Medical Association are Dr. Jack Parker of Greenville, Dr. Kenneth M. Lynch of Charleston, and Dr. Julian Price of Florence.

Of wide interest is the announcement of the wedding of Mrs. Daisy S. Guy and Dr. William S. Judy of Greenville, which was solemnized on Saturday, the eighth of June, at St. George.

Dr. F. P. Coleman, who practiced in Columbia before entering the Army, has opened offices in Richmond, Virginia, for the practice of general and thoracic surgery.

Drs. F. E. Zemp, Emmett Madden and O. B. Mayer recently attended the meeting of the American College of Physicians in Philadelphia.

Dr. W. W. Edwards announces his separation from the military service and the resumption of practice in Greenville.

Dr. R. S. Matthews, formerly on the staff of the South Carolina State Hospital, is now Medical Director of the Edgewood Sanatorium in Aiken.

Dr. Jack Parker of Greenville, has returned from Chicago where he went to take the examination for certification by the American Board of Obstetricians and Gynecologists.

Dr. William Atmar Smith of Charleston has been named by the Veterans' Administration as Chief of Tuberculosis Division No. 5, which has headquarters in Atlanta. Dr. Smith is one of thirteen outstanding tuberculosis specialists named to direct the VA program for tubercular veterans.

Dr. Leon S. Bryan has been discharged from the Navy and has reopened his offices in Columbia for the practice of dermatology and syphilology.

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PUBLIC HEALTH NEWS

500 ATTEND SOUTH CAROLINA PUBLIC HEALTH ASSOCIATION CONVENTION AT MYRTLE BEACH

Dr. Sheriff Becomes New President; Miss Blackburn Made President-Elect

One of the finest programs ever arranged for public health workers in this State was presented before approximately 500 members and guests of the South Carolina Public Health Association at its 23rd Annual Meeting at Myrtle Beach May 27, 28 and 29. Total registration of members for the three days numbered 377.

Held in the Gloria Theater and presided over by Dr. M. J. Boggs, President of the Association and Abbeville County Health Officer, the meeting featured inspiring addresses by Governor Ransome J. Williams; Dr. W. K. Sharp, Jr., Medical Director, USPHS, District No. 2, Richmond, Virginia; Dr. James McLeod of Florence, President of the S. C. Medical Association; Dr. Ben F. Wyman, State Health Officer; Dr. Boggs, and other outstanding leaders in the field of public health.

In his address, Governor Williams paid high tribute to the "splendid work being done by public health workers in South Carolina," and expressed confidence in the hope that the great progress made in public health in this State in the recent past would, under the leadership of Dr. Wyman, continue into the years that lie ahead.

Highlighting the meeting, was a delightfully informal fish stew, swimming and dancing party held at Myrtle Beach State Park Tuesday afternoon and evening. More than 400 persons enjoyed the food, fun and frolic which had been arranged under the capable direction of Dr. C. L. Guyton, Chairman of the Program Committee, with the assistance of Messrs. William "Crow" Weston and Hart Hiers.

Prior to adjournment Wednesday afternoon, Dr. Boggs turned the gavel over to the President-Elect, Dr. Hilla Sheriff, Director of the State Board of Health's Division of Maternal and Child Health, who was installed as President for the ensuing year. Elected to serve with Dr. Sheriff were: Miss Laura Blackburn, Consultant Nurse, Division of Maternal and Child Health, President-Elect; Dr. L. A. Nimmons, Health Officer for Dillon, Marion, Marlboro and Lee Counties, 1st Vice-President; Charles W. Harrell, Sanitary Engineer, Pee Dee District, 2nd Vice-President; and Mrs. Frank George, re-elected Secretary-Treasurer. Dr. Ben F. Wyman, State Health Officer, was re-elected to represent the South Carolina Public Health Association on the Governing Board of the APHA.

Papers presented on the program included:

"The Future of Medicine," James McLeod, President, S. C. Medical Association, Florence, S. C.

"Public Health Administration from a National Level," W. K. Sharp, Jr., Medical Director, USPHS, District No. 2, Richmond, Va.

"Quantitative Tests for Syphilis with Special Reference to the Mazzini Tests," J. F. Mahoney, Medical Director, VD Research Laboratory, U. S. Marine Hospital, Staten Island, New York.

"Parasitic Diseases with Special Reference to Malaria," H. W. Brown, M.D., Professor of Parasitology, Columbia University School of Public Health, New York City.

"Influence of Antepartum Guidance on Intrapartum and Postpartum Events," J. Decherd Guess, M.D., Obstetrician and Gynecologist, Greenville, S. C.

"The Place of the Health Educator in the Local Public Health Program," Eunice N. Tyler, Ph.D., Associate Professor of Health Education, University of North Carolina, Chapel Hill, N. C.

"Recent Developments in Field Training Programs and Trends in the Field of Environmental Sanitation," Ellis S. Tisdale, Senior Sanitary Engineer, Acting Chief, Training and Education Division, USPHS, Atlanta, Ga.

"Public Health Nursing," Miss Ruth G. Taylor, Director, Nursing Unit, Children's Bureau, U. S. Department of Labor, Washington, D. C.

"Phases of Rodent and Typhus Control Affecting the Generalized Sanitation Program," George S. Bote, Typhus Consultant, Bureau of Sanitary Engineering, Florida State Board of Health, Jacksonville, Florida.

"Economics of Tuberculosis Control," Norvin C. Kiefer, Surgeon, Office of the Chief, Tuberculosis Control Division, USPHS, Washington, D. C.

"Organization and Plan of Infantile Paralysis Chapters in South Carolina," Julian S. Martin, State Representative, National Foundation for Infantile Paralysis, Columbia, S. C.

"The Program of the National Foundation for Epidemic Emergency and Year 'Round Medical Care of Infantile Paralysis," Hart Van Riper, M.D., Ass't. Medical Director, National Foundation for Infantile Paralysis, New York City.

"The Modern Treatment of Infantile Paralysis," Robert L. Bennett, M.D., Director of Physical Medicine, Georgia Warm Springs Foundation, Warm Springs, Georgia.

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BOOK REVIEWS

Rypins, H.: Rypins' Medical Licensure Examinations. 5th enl. ed. Phila., Lippincott, (c1945) \$6.00.

It is extremely difficult for a single individual to properly evaluate the ten separate divisions or fields of medicine, viz. anatomy, physiology, chemistry, bacteriology, pathology, hygiene and preventive medicine, obstetrics and gynecology, medicine, pharmacology, and surgery, into which the book is divided. This review is not intended as a critical examination of the subject matter of each field, as it would be viewed by the specialist, but it is an attempt to assess the value of the book to students preparing for an examination.

This volume is a valuable contribution of the various authors and doubtless will be of great assistance to those who are preparing for examinations of the state boards. It is worthwhile, convenient, and stimulating. The many good points and the excellent discussions cannot be singled out due to lack of space. Certain short-comings, however, will be mentioned.

The volume needs better editing to insure correlated discussions of the same subjects in the basic science sections and in the clinical sections, or else to insure an adequate discussion of important topics by at least one author. It may be that indexing is insufficient but there is no listing of medullary centers, internal capsule, prescription writing, pediatrics, embryology, micturition, or visual pathways, to mention some topics which are frequently included in examinations.

In general, physiology is one of the poorer sections. Neuroanatomy is treated too superficially and identifies several spinal cord pathways in terms of the old nomenclature. In the section on Chemistry, too many of the definitions cover terms which are needed by a student during his course work but not on state board examinations. Despite these criticisms, the volume should be of real service to anyone preparing for licensure examinations.

F. W. K.

"Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the A. M. A. for 1944" Chicago, 1945, pp. 235.

Reports and editorial comments on them from J. A. M. A. plus less important reports from the Minutes of the Council comprise half of the volume. Articles on results of electron microscope research on pathogenic bacteria, rickettsia and viruses, on prophylaxis by H. pertussis vaccine, and on appraisal of new drugs are reprinted from the Journal.

The review of electron microscope studies seems particularly significant.

J. H. H.

Mason, R. L. and Zintel, H. A., Editors. Preoperative and Postoperative Treatment. Second Edition. W. B. Saunders Company. Philadelphia and London, 1946.

This lengthy tome is an excellent symposium on practically every phase of modern preoperative and postoperative therapy. Its authors consist mainly of the leading men in the medical schools of Boston,

and in particular of those at Harvard. Each writer is especially qualified in the various fields of general and regional surgery surveyed.

Each topic is presented in exhaustive detail, in one even to the point of stating that a straight razor is preferable to a safety razor for preparing an operative field, because the latter is apt to become clogged with hairs. In addition to its value for more general information, however, the book is exceedingly valuable from the standpoint of its analysis of disease and pre- and postoperative care in relation to pathological physiology and chemistry. Great stress is placed on all available knowledge in these two subjects, and hence on the rationale for all studies and procedures recommended.

In contrast to its general splendor, it would seem to the reviewer that insufficient credence is placed in the fluid loss theory of so-called traumatic shock, and there is little reference to the importance of impending or incipient shock. Too, the book suffers by not having a section devoted specifically to chemotherapy. But in spite of a few shortcomings, the book can be recommended highly to the student and graduate of surgery alike.

E. F. P.

Masserman, J. H.: Principles of Dynamic Psychiatry, including an integrative approach to abnormal and clinical psychology. Phila., W. B. Saunders Co., 1946. \$4.00.

Masserman attempts to evolve a basic approach to dynamic psychiatry. Conversant with the psychobiology of Meyer, which formed his introduction to psychiatry, and the newer viewpoints of the American psychoanalytic school, the author seemed to be displaying a refreshing eclectic attitude when he began to carry out his excellent series of studies on "neurotic" animals. In the preface to "Essentials of Dynamic Psychiatry" he promises to select the wheat from the chaff of these varying schools, and to restate basic dynamic mechanisms. The book shows great cleverness in the author's appraisal of the present scene in psychiatry. One cannot read it without appreciating that a vigorous intellect is at work. However, the promised goal, in the opinion of the reviewer, is never reached. The interpretation of the factual material in the clinical histories and the elucidation of the dynamics are definitely colored by the author's strong psychoanalytic orientation. One has the feeling that the animal experiments and the verbalizations about other schools are rendered lip service only and at heart Masserman is an analyst pure, but far from simple. This inevitably leads to another criticism. At no time has it been so essential to present psychiatry clearly and lucidly to the reading medical public. The author has not done this. An overuse of psychiatric "jargon," and an almost sophomoric pleasure in using uncommon words will inhibit the usefulness of the book for the general medical reader.

O. B. C.


DEATHS

Robert Emmet Seibels, Jr.

Dr. Robert E. Seibels, Jr., 28, was accidentally killed on May 12, in a skiing accident on Mt. Baker, Washington. Dr. Seibels received his Bachelor of Arts degree from the University of the South at Sewanee, Tenn. He then entered Duke University from which institution he was graduated in medicine in December 1943. He entered the navy as a physician in December 1944 and served as the junior medical officer on the USS San Diego. The young doctor received official commendation from Admiral Spruance, and was the recipient of the Naval ribbon for medical service rendered in the case of 34 severely scalded sailors from a destroyer. Dr. Seibels worked three days and nights among the wounded, and as a result no lives were lost. Surviving are his parents, Dr. R. E. Seibels and Mrs. Alice Crosby Seibels, and one brother, all of Columbia.

Charles A. Speissegger

Dr. Charles A. Speissegger, 65, died at a hospital in Charleston on June 3, after many years of ill health. Dr. Speissegger received his education at the College of Charleston and the Medical College of the State of South Carolina. After serving his internship in New York he returned to Charleston and engaged in the general practice of medicine. For some years before he retired Dr. Speissegger was an affiliate professor at the Medical College. Surviving are his widow, a daughter and a son.



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The Journal of the South Carolina Medical Association

AUGUST, 1946

VOL. XLII, NO. 8

Article	Author	Page
Anti-Histamine Agents	Wm. H. Kelly, M.D.	209
Hot Weather Pediatrics	J. I. Waring, M.D.	211
Amenorrhea, Its Causes and Treatment	Rowland F. Zeigler, Jr., M.D.	213

Editorials — The Ten Point Program — News Items — Public Health News
Book Reviews — Correspondence

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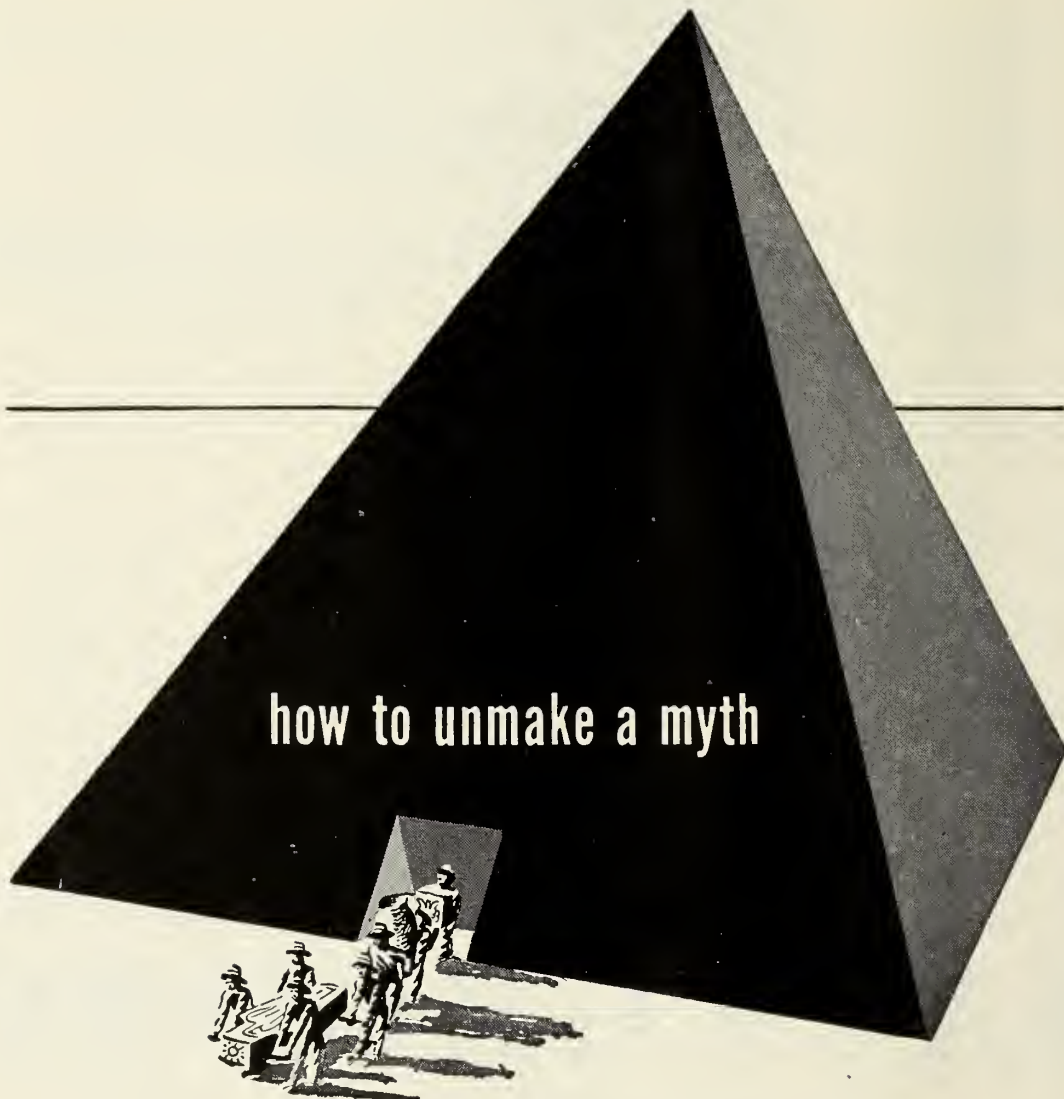
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1. Am. J. Dis. Child. 66:1 (July) 1943



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OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

August, 1946

NUMBER 8

Anti-Histamine Agents

BY WM. H. KELLY, M.D., CHARLESTON, S. C.

Histamine, a chemical derivation of the amino acid histidine, occurs naturally in the tissues of many animals and of plants as well¹. In mammals large amounts are present in the cells in a bound or inactive form which under certain influences is transformed into the active agent. A product of bacterial growth, also it may be absorbed from the gastrointestinal tract in important amounts in man.

Histamine exhibits a marked but ubiquitous pharmacodynamic activity. Few tissues of the human body fail to show a demonstrable reaction of some kind. For the purposes of this report however only particular effects need be described. Upon the cardiovascular system it produces dilation of arterioles and capillaries with an increase of permeability in the latter. Intracutaneous injection of histamine evokes a "wheel and flare" reaction simulating urticaria. Subcutaneous injection of histamine in suitable amounts produces a generalized blush of the skin, a throbbing headache, and an increase of glandular secretion particularly of the pyloric glands. In the presence of bronchitis, bronchospasm may be induced. Histamine also increases the tone and activity of certain smooth muscles, notably of the gastro-intestinal tract and of the uterus.

The resemblance between certain effects of histamine and some manifestations of allergic disease has given rise to a general theory that histamine metabolism is disturbed in the latter. As to whether the postulated disturbance involves an excessive liberation of bound histamine or a failure of destruction or elimination of released histamine is not made clear by the accumulated evidence. In any case it seems of interest to recount some recent attempts in one direction or another to effect a control of histamine metabolism in allergic disease and otherwise.

In 1937 Roth and Horton² recommended the use of graduated serial injections of histamine in the

treatment of physical allergy—chiefly hypersensitivity to cold. In 1940 Horton, et al², described a type of fleeting cephalalgia in late middle-aged individuals characterized usually by severe throbbing unilateral pain and lacrimation on the side of the pain which was said to respond to the same type of treatment. In 1940, Shelden and Horton introduced the same procedure in the treatment of Meniere's Syndrome. In 1940 Miller and Piness³ recommended serial injections of histamine in chronic allergic disease generally. As yet these preliminary reports do not seem to have received the confirmation necessary to place this therapeutic procedure beyond the experimental phase of development.

In 1943 Cohen and Friedman⁴ introduced a new compound, para-aminobenzoyl histamine ("Hapamine"—Parke-Davis) for use in hyposensitization therapy to control histamine metabolism. As yet this procedure seems no more securely established in the treatment of allergic disease than the use of histamine alone.

Normally histamine activated in the tissues is apparently destroyed by the enzyme histaminase. In the paper on hypersensitivity to cold by Roth and Horton² the trial of this agent was suggested also in treatment. In 1940, Keeney⁵ reported encouraging results from the use of histaminase in the treatment of hay fever. As yet this measure lacks sufficient confirmation for general acceptance. Furthermore no convincing evidence has been adduced to show that histaminase is not destroyed by gastric juice when exhibited by mouth.

During the past 2 years interest has become revived in a comparatively new group of synthetic chemicals which were first discovered in 1937 by Bovet and Staub⁵ of France to act antagonistically to histamine. Of these two are of noteworthy interest: Benadryl (Parke-Davis Co.) and pyrabenzamine (Ciba Co.). The first is released for general sale. The latter is as yet in the experimental phase. The pharmacological activities of the two are described as similar though not identical. The resemblance seems close

enough that it may suffice to describe the better known Benadryl without attempting to draw comparisons between this and pyrabenzamine.

Chemically Benadryl is a tertiary amine. In form it is a white crystalline powder, soluble in water and alcohol, and stable at room temperature. It is readily absorbed from the gastro-intestinal tract and may be administered by the intramuscular or intravenous routes when necessary. By the mouth the effects of the drug appear within 30 minutes and last for from 6 to 8 hours. The fate of the drug in the body has not as yet been adequately studied. The range of safe dosage is broad. Adults may take by either route up to 300 mgms. in divided doses in 24 hours. Children under 12 years of age may receive from 10 to 25 mgms. as the elixer every 6-8 hours. The cost of the treatment is very reasonable.

Pharmacologically Benadryl antagonizes the more important actions of histamine. In addition, it possesses atropine-like properties in that it tends to neutralize the effects of acetyl choline. In combatting induced anaphylaxis in guinea pigs it is said to have 15-30 times the potency of aminophyllin. It reduces markedly the spasmogenic action of histamine on smooth muscle and the size of histamine skin wheals. Upon the secretion of hydrochloric acid, the effect of benadryl is inconsistent.

Therapeutic results reported⁵ from the use of Benadryl thus far appear encouraging in the allergic diseases and perhaps certain other disorders. In urticaria, angioneurotic edema and serum or drug sickness up to 90 per cent of cases are said to show satisfactory improvement. In hay fever and vasomotor rhinitis more than three-fourths of cases responded. In bronchial asthma and in eczema almost two-thirds of cases improved. A number of other presumably allergic disorders showed similar improvement. Interestingly enough, in a small group of cases the drug is said usually to have given relief in dysmenorrhea and pylorospasm. The benefits are of course symptomatic and last only until the drug effect wears off. However, in cases treated over a period of months no loss of therapeutic effect was noted.

The chief limiting factor in the use of Benadryl would appear to be certain unpleasant side effects. Of these the more disturbing ones are: Drowsiness or sleepiness, giddiness, faintness, and dryness of the mouth. Others of less importance are described. With full dosage 80 percent or more of patients complain of untoward reactions. Where the desired effects can be obtained with minimal amounts only 20 percent so complain. When giddiness occurs it is important that the patient be warned against operating vehicles, walking unescorted in traffic, etc., to avoid accidents. The potential danger of addiction in those who react with sleepiness is not fully evaluated perhaps but does not appear important at

this time. It is of note that some patients experience unpleasant sensations after the first dose which do not recur upon further use of the drug. It need not be discontinued because of these except when they are more disturbing than the original complaint for which the drug was given.

Experience remains insufficient to allow of a final evaluation of the usefulness of Benadryl and of related drugs at this time. It presently promises, however, to be an addition of distinct though limited worth in the symptomatic control of the allergic and perhaps of certain other diseases. The usefulness seems to be greatest in the acute or episodic allergic disorders. In the management of chronic or intractable allergic diseases it is extremely doubtful if the drug will supplant orthodox measures. In these however it may prove helpful during the interval required for investigation and the institution of the usual treatment. Likewise in those refractory cases with allergic manifestations the drug may in some way make up for the deficiencies of the current procedures.

DISCUSSION

Dr. van de Erve: Dr. Kelly has presented comprehensively the new anti-histamine agents and drugs. It might be profitable to emphasize further certain points he has brought out. These are theoretically valuable only in those conditions in which the clinical manifestations are produced by a local vasodilatation and edema formation which is caused, we believe at present, by the release of a histamine-like substance in the tissues in situ. These drugs should be used, as far as possible, only in that type of allergic reaction. There should be a very definite selection or indication for them. I don't believe that a cough, a drippy nose, an itch in the skin, or a dermatitis is sufficient indication, in itself, for the use of Benadryl or Parabenzamine unless you have ruled out all other common causes for it.

So far, in my experience, these drugs have been of definite value in urticarial eruptions and hay fever, not so good in asthma and very little in atopic dermatitis. It doesn't quite coincide with the table that was shown on the screen in regard to asthma, chronic eczema and atopic dermatitis all of which are frequently conditioned by an auto-sensitization to bacteria and body-own homologous protein sensitization. Certainly, we must remember that the sulfonamides, penicillin, streptomycin and the antihistamine drugs have one thing in common. They have the power in many cases of stopping, or arresting, a pathological process or infection—that is as far as they go. They do not immunize or desensitize. They do not take the place of a thorough study of the patient and a search for and removal of the cause and desensitization to the agent that has caused the trouble. They are helpful and may be used along with thorough studies but should be used only as a help and not as a cure. Immunity or resistance does not result from the use of these agents. Nevertheless they are very valuable. I think they represent a very definite step forward towards that ideal which we have of altering the constitutional status or fundamental background, rather than playing around the fringes of sensitization and allergy.

Dr. J. Richard Allison: This paper of Doctor Kelly's is very important as it concerns a new drug

which evidently is destined to play an important role in the treatment of certain diseases. I am thoroughly in accord with Dr. van de Erve's warning note in regard to the use of this drug. We in the medical profession certainly have a tendency to make unwarranted claims for many remedies and by too promiscuous use of such remedies cause unnecessary bad results which reflect adversely on the drug. There may be complications and therefore one should watch carefully for reactions. We have used Benadryl extensively during the past four months and had a patient who lost the use of the lower extremities for two days and we were told by another doctor of a child who slept for two days after the use of Benadryl. The advertisements that benadryl has had will certainly cause its widespread use among the laity without a physician's knowledge. Already, I have had several patients to come to the office with capsules of benadryl that have been given to them

by the druggist. I was very much interested in the list of skin diseases that Doctor Kelly showed in his chart. It seems to me that it includes many skin diseases that are not caused by histamine. I think it very essential that we should remember at all times that benadryl is an antihistamine drug and that we should confine our use of this drug to those diseases which are due to excessive formation of histamine in the blood tissues. Atopic Eczema for example is an antigen antibody disease and has never been considered due to the presence of histamine. Then again, I can not see how benadryl would affect in any way the course of Dermatitis Venenata. I have never heard that in poison oak, for example, that the mechanism causing the eruption is due to the formation of histamine.

Hot Weather Pediatrics

J. I. WARING, M.D., CHARLESTON, S. C.

About a week ago I was informed by your worthy secretary that I was invited to join the Pee Dee doctors in a meeting in which we all might bemoan the impending trials of approaching hot weather. Feeling much honored by this invitation, I have made an effort to herd together a few wandering thoughts on the subjects which plague the pediatrician and the general practitioner during the hotter months of the year, when vicious germs give up their winter activities in the respiratory tract, and turn over the field to the busy invaders of the skin and intestinal and other tissues. With tremendous apology, I might presume to paraphrase Hippocrates vaguely in saying that while my time has been brief, and my art not too long, your judgment may perhaps be more charitable than difficult in evaluating this paper.

It is naturally impossible for a pediatrician to talk without talking of diarrheas. There may be justification in this subject because of developments of fairly recent years in regard to causes and to treatments. In spite of the accumulated knowledge of centuries we are still using some of the old remedies as unsuccessfully as ever. Benjamin Rush wrote 150 years ago of what was called in Charleston "The April and May Disease," the early debut of the diarrheal conditions which would carry many of our ancestral relatives to an early burial. This "disease of the season" still appears with unfortunate regularity, although sanitary knowledge has done much to reduce its ravages.

During the past winter we have seemed to see an unusual number of diarrheal conditions which for want of definite identification we have considered to be probably due to some virus not yet specified. Now we are seeing a different type of disorder which will likely be increasingly common and represents an infection with the shigella of dysentery, and while more severe in its course, is fortunately much more amenable to treatment than was the diarrheal disease of colder weather.

I think we can assume that real dysentery or shigellosis is fairly common over the state, although few doctors report their cases. It is true that positive identification may be difficult without bacteriological diagnosis, but a clinical picture including a sudden onset, fever, cramps, mucus, blood, and pus in the stools must be viewed as dysentery, at least suspiciously enough to give sulfonamide therapy, although such a combination of symptoms may come from an infection with salmonella or other organism, and will not respond to the same treatment. On the other hand, many, and possibly most infections with shigella may show a much milder picture, yet still require the same treatment to prevent more tedious and serious developments. Many of us can remember the horrible dysentery not so many years ago, when one must sit by and see a child agonized by cramps, expelling quantities of bloody mucus, and wasting day by day over a long and painful period of illness. Just as sulfonamides have made most pneumonia a shorter and safer disease, so have they checked the vicious progress of dysentery.

I know of no definite diagnostic rule which will indicate when diarrheal disease is real dysentery.

Even stool cultures are not entirely satisfactory, and treatment cannot be delayed until a report comes back. If the cause of the diarrhea is not obviously a simple dietary disturbance or if signs of toxemia, or typical stools are present, treatment is indicated with sulfadiazine or sulfathiazol, rather than with the less absorbable sulfaguanidine or sulfasuxidine. If vomiting is present, these drugs may be given intravenously or subcutaneously with benefit. It seems that we must be very specific in telling most parents that doses must be given regularly, completely, and for a long time, for if the mother's fickle judgment is left to range, it is likely that medication will be stopped at the first sign of improvement, and just as likely that relapse will occur very promptly. Blood plasma, various fluids, and amino acids all have important parts in maintaining fluid balance. Barbiturates and paregoric help, but paregoric is given to allay pain, not to check activity of the bowel—Castor oil and calomel should be given to the grandmother or the doctor who prescribes them. Most of the various proprietary preparations so well advertised have little value in dysentery. The patient should be kept as cool and quiet as possible. After a period of 12 to 24 hours of starvation, the diet should be liquids, boiled skimmed milk, acidified or cultured buttermilk, fresh scraped fruit, quantities of fluids and more than the usual allowance of vitamins. As a point of public health, one should see that dysentery stools are not exposed, as it seems that most infections are spread by flies.

The child's skin takes its share of bites, scratches, cuts, and infections in the summer. Without pretending to the superterminology or the hypertherapy of the dermatologist, one may treat most of these troubles simply and effectively. Ordinary heat rashes, miliaria, or whatever term you choose, come to you suspected of being measles, scarlet fever, eczema and what not. The first step in treatment of the infant is to eradicate the heavy shirt which has been the subject of endless debate and discomfort. Mild alcohol bathing and calamine lotion seem to do as much as anything; ointments only seem to aggravate.

Impetigo seems to throw a certain horror into the mother's soul, although most of it responds readily to a 20% sulfathiazol suspension or a weaker ointment, provided the crusts of the lesions are removed thoroughly and frequently. Lack of diligence in treatment seems to be the difficulty with many cases. Various fungus infections of the skin seem to do reasonably well with the old Whitfield's ointment, weak iodine solutions, or tar preparations. Interdigital infections are not as easily eradicated. Larva migrans, due to larva of the cat or dog hookworm, seems to be best treated by freezing with ethyl chloride or solid carbon dioxide, although you may wish to try the method of fresh onion poultices lately described in the Southern Medical Journal. Fuadin by injection has failed me in a very limited trial, but various advocates for it are to be found.

There is new hope for the sufferer from plant dermatitis in the use of benadryl, newest antihistamine substance, which has burst upon us with a high reputation not yet completely sustained. It does seem to be very helpful in hay fever and urticaria from various causes, such as serum sickness (2 mg. per lb. per day). Perhaps it will help papular urticaria (or lichen urticatus, or strophulus, as you choose), one of the summer dermatological problems which often strains the patient's loyalty to your treatment to that same unfortunate point to which eczemas often push it. This itching, secondarily infected, unresponsive ailment may be allergic. Skin tests are worthless, elimination diets seem to fail, and sometimes only a change to a cooler climate gives relief. This sudden improvement with change of scene would seem to take the disease out of the nebulous realm of the simpler allergies into the most rarefied atmosphere of physical allergic changes. Be that as it may, let us hope that benadryl will be a palliative.

The common ammoniacal diaper rash may be a problem which has been blamed on various soaps and materials but can be solved generally by the use of a mild antiseptic oil for cleansing after the passage of the stool and the liberal use of powdered boric acid to prevent decomposition of the urine, along with exposure of the buttocks to the air and elimination of rubber breeches.

But this is enough of simple pediatric dermatology, and it is too tedious to list all of our approaching summer troubles. Let us hope that poliomyelitis will spare us this year, but if it comes, let us avoid tonsillectomy with the danger which it carries of opening avenues of infection. In fact, let us avoid all tonsillectomies for which there is no definite justification, especially the acute remunerative type. Despite our hope, it is likely true that we will have to face the problem again, especially in reference to the apprehension of parents and unanswerable questions concerning flight, summer camps and hopeful prophylactic measures—Unfortunately, when the disease comes, we have little that is new or effective to offer, although we must perforce use hopefully the method of hot packs which still remains under discussion as to its true value—

With bites of ticks and other insects we must be aware of the rather remote possibility of rickettsial diseases, and if typhus occurs locally, we must think of using the harmless vaccine for endemic typhus as a prophylactic measure. Let us hope that streptomycin will fulfill its hypothetical promise in typhoid fever and other infections.

One minor word on malaria, which I believe is often not what we think it is. Every summer I see children with an acute disease marked chills, fever, and enlarged spleen, who show no parasites in the

blood and recover in a few days with or without quinine or atabrine. Probably our suspicions are too active, and we assume that our treatment has done what has really been accomplished by natural cure. What this disease is I do not know, but it is easily confused with malaria.

The barefoot boy is preparing for his usual collection of nails and splinters and can enter the season

more safely if he is protected by tetanus toxoid. If he sustains an injury, another dose of toxoid will protect him better than will antitoxin—If he must have antitoxin, benadryl will probably relieve the delayed urticaria which may follow the serum. As for the physician, a therapeutic vacation is the best medicine that can be taken, and I trust that you all will have a large dose of it.

Amenorrhea, Its Causes and Treatment

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Amenorrhea is the complete absence of menstruation, and may be of short or long duration, although Rock¹ states that the term should be reserved for those cases in which there has been no flow for four months or longer. It is termed *primary* when menstruation has never occurred, and *secondary* when menstruation has previously occurred. Hypomenorrhea (scanty flow) and oligomenorrhea (few periods) may be a stage in the development of amenorrhea, or they may be unimportant. It is the change in amount or actual diminution in bleeding, as related to the patient's own individual previous cycle, that may be important. The following classification for etiologic purposes is derived from both those of Fluhmann² and Freed³:

I. Physiologic Amenorrhea

II. Nonphysiologic Amenorrhea

1. Cryptomenorrhea
2. Amenorrhea of Uterine Origin
3. Postcastration Amenorrhea
4. Functional Amenorrhea

1. *Physiologic Amenorrhea* is that which occurs before puberty, during pregnancy and lactation, and in the postmenopausal period. The menarche may appear early or late, as puberty is a "phase in sexual development rather than a moment."¹ However, amenorrhea may be assumed if there has been no menstrual onset by the age of 18 years. Amenorrheas of pregnancy and the postmenopausal time need no comment. Lactation amenorrhea is very inconstant.

II. Nonphysiologic Amenorrhea

1. *Cryptomenorrhea* or pseudo-amenorrhea is absence of menstrual flow due to mechanical obstruction; a complete physiologic cycle, however is present in both the uterus and ovaries. Congenital malformations such as imperforate hymen or atresia of the vagina are the most common causes, but occasionally obstruction may result from new growths, foreign

bodies or strictures that may follow inflammation, delivery trauma, plastic surgery, and radiation or cautery lesions.

2. *Amenorrhea of Uterine Origin* is that due to the loss of an active endometrium. Obviously, hysterectomized cases and cases of congenital uterine absence fall into this group. With the intact uterus, there may be mucosal atrophy due to extensive necrosis after severe puerperal infection, irradiation, radical chemical or mechanical treatments, tuberculosis endometritis, and other unknown causes. Crossen⁴ mentions hyperinvolution of the uterus following pregnancy as a rare occurrence that may so modify the endometrium as to interfere with menstruation.

3. *Postcastration Amenorrhea* refers to those cases in which the ovaries have been extirpated or have undergone atrophy from irradiation.

4. *Functional Amenorrhea* may result from a multitude of conditions, both endocrine and nonendocrine. Normal menstruation depends on good health in general, and its disappearance is often the first indication of a systemic disease. Often, the exact mechanism concerned with amenorrhea is not clear, but the focal point of the disturbance is always the ovaries, which fail to undergo a normal cycle. This may be due to some influence exerted on the gonads directly, or indirectly through interference with the gonadotropic function of the anterior hypophysis. In considering etiologic factors of functional amenorrhea, the normal interplay and harmonious relationship of the pituitary and ovarian hormones must be kept in mind. Since amenorrheic patients from this group will comprise the bulk of those seeking gynecologic aid, and since these patients are presenting themselves merely with a symptom, it is essential that an effort be made to determine the

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[°]Read at the meeting of the Fellows of the Alton Ochsner Medical Foundation, April 12, 1946, in New Orleans.

causative factors. The causes of functional amenorrhea are almost legion and necessitate further classification into the following groups of recognized causes:

- A. Pituitary
- B. Ovarian
 - (a) Hyperhormonal
 - (b) Hypohormonal
- C. Thyroid
- D. Adrenal
- E. Pancreas
- F. Obesity
- G. Nutritional
- H. Debilitating Diseases and Intoxications
- I. Psychic
- J. Mental Diseases

Pituitary

Mazer and Israel⁵ state that "the pivotal role of the anterior lobe of the pituitary gland in the initiation and control of ovarian function is no longer debatable," and that "the normal ovarian cycle (follicular growth, ovulation, and luteinization) is totally dependent upon the successive and integrated action of the two pituitary sex hormones." Because this gland is the "motor" of sexual function, any organic or functional derangement of it may result in amenorrhea. It is believed that the majority of amenorrhea cases is due to pituitary malfunction. The degree of anterior pituitary hormone deficiency may be relative or complete; and this gonadotropic hormone secretion may be lost temporarily or permanently as a result of trauma, hemorrhage, infection, tumors, inadequate nourishment, or constitutional inherent defect. The anterior pituitary functions normally as a unit, as does the hypothalamus, but it is well to remember that each structure is susceptible or vulnerable to alterations in the other.

Often, when a state of relative hypopituitarism exists, a definite diagnosis is almost impossible to make and may depend largely on the dysfunctions of target hormonal areas. For instance, one of the most evident consequences of pituitary derangement in the adult female is amenorrhea with subsequent genital atrophy. The menstrual cycle has been rightly called an accurate barometer of pituitary function.

There are, however, certain definite clinical entities and syndromes of pituitary disease, which may present characteristic findings along with amenorrhea.

Adiposogenital Dystrophy (Froehlich's Syndrome) is due to hypothalamico-pituitary disturbances and is characterized by a singular type of obesity, underdeveloped genitalia, scanty menses if any, osseous changes, placidity, headache, minor visual field defects, and usually decreased urinary estrogen and gonadotropin values. The distribution of the obesity is distinctive. It is most marked in the lower abdomen, nates, and upper portions of the thighs, shoul-

ders, and breasts; the extremities below the elbows and knees are free from adiposity. Often the forearms, hands, fingers, legs, and feet are relatively short, and the neck is short. Diagnosis is frequently difficult because of absence of some of the cardinal signs, but this syndrome is quite rare and probably it is too often conveniently applied to obese women. The Lawrence-Moon-Biedl Syndrome must be differentiated. Its signs are the same as adiposogenitalism plus retinitis pigmentosa, mental deficiency, and a hereditary tendency and some congenital anomaly, most frequently polydactylism. Dercum's Disease (Adiposis Dolorosa) is another lipodystrophy which is similar except that it is characterized by obesity distributed in painful symmetrical lumps, asthenia, melancholia, and various neurologic manifestations.

Pituitary Cachexia (Simmond's Disease) illustrates dominance of the hypophysis over functions of the entire endocrine system of its target glands. It is due to sudden and complete loss of anterior lobe function and originates during or immediately after pregnancy in almost 50 per cent of the cases. An acute pituitary necrosis may follow postpartum hemorrhage. This horrible malady, often referred to as "Nature's hypophysectomy experiment,"⁶ is more common than generally believed. There are failures in gonads, adrenal cortex, and thyroid gland as a result of disability in the master pituitary. The cardinal symptoms are emaciation, amenorrhea, precocious senility, marked asthenia, intolerance to food, loss of pubic and axillary hair, flabbiness and dryness of the skin, rapid decay of teeth, genital atrophy, hypotension, and marked hypometabolism. True Simmond's disease uniformly results in death.

Pituitary Adenomas may arise from either of the three types of epithelial cells in the anterior lobe. Their symptoms are generally produced by pressure on neighboring structures, or by intrinsic hormonal derangements, or by both. The chromophobe adenoma is the most common and is usually characterized by amenorrhea and associated sterility, progressive optic atrophy, headache, obesity at times, and x-ray evidence of sella distortion. Basophile adenoma (Cushing's Syndrome), which arises from the cells believed to produce the gonad-stimulating hormone, produces a complex syndrome of amenorrhea, facial and trunk obesity (the painful "buffalo type"), hirsutism, thickening of the skin, hyperglycemia, glycosuria, hypertension, purplish abdominal striae, polycythemia, osteoporosis, and weakness. Acidophile adenoma, which arises from the cells considered the source of the growth hormone, results in gigantism and acromegaly. The onset of acromegaly is insidious. There is eventually osseous proliferation of the terminal phalanges, tarsal, and carpal bones, thickening of the jaw, and prominence of all anatomic protuberances. Soft tissues of the face, hands, and feet are thickened, the tongue is enlarged, and there is often glycosuria, increased metabolism, and enlargement of the sella turcica.

Frommel's Disease is a postpartum complication with persistence of lactation for varying lengths of time after discontinuation of nursing, resulting in constitutional drain with cachexia, genital atrophy, and amenorrhea. It is possibly of pituitary etiology. Paradoxically, Gilbert⁷ reported the persistence of lactation for 16 years without interfering with cyclic uterine bleeding.

Ovarian

Amenorrhea due to ovarian dysfunction was formerly thought to mean ovarian failure, but assays and endometrial biopsies have shown that amenorrhea may result from a number of different patterns in the secretion of the estrogenic hormone. Frank⁸ has shown that estrogen excretion of the urine in patients with amenorrhea may be elevated above normal, depressed far below normal, or only slightly below normal. This led logically to the terming of amenorrhea as hyperhormonal and hypohormonal. This apparent paradox of two opposite estrogenic states leading to failure to menstruate, has been explained with both clinical and experimental evidence. The "bleeding threshold," a term used to signify the level of estrogen in the uterus and blood stream at which point a decrease of estrogen level will result in uterine bleeding, is the key factor. An estrogen level above or below the threshold will not cause bleeding; a fall or drop of estrogen past the threshold is necessary for bleeding.

Hyperhormonal (hyperestrogenic) amenorrhea may occur as a result of the presence of numerous small cysts in the ovary containing active follicular cells which are secreting a steady, continuous supply of estrogen. It may occasionally occur from the presence of a granulosa cell tumor which is maintaining a continued high level of estrogen. Functional amenorrhea may persist in these cases until such time when the estrogen level drops below the threshold point. In these types, the uterus usually enlarges and develops a hyperplastic endometrium. Corpus luteum cysts and certain rare ovarian tumors containing cells resembling those of a corpus luteum may secrete both estrogen and progesterone in constant and sufficient amounts to prevent bleeding for varying periods. In these cases, the endometrium may resemble that of pregnancy, and often differential diagnosis is difficult, from ectopic gestation in particular.

Hypoestrogenic amenorrhea is much the more common type, and such intrinsic ovarian failure may be due to infections, ischemia, developmental inadequacy, or tumors. Ovarian insufficiency frequently occurs as a result of the invasion or mere embracement of the ovaries by local pelvic infections, or it may occur as a result of blood borne inflammation in certain contagious diseases (mumps and scarlet fever). Interference in ovarian blood supply may be the result of malpositions, pressure, or surgical trauma. In ovarian agenesis, where there is either complete absence of the ovaries or complete unresponsiveness

to pituitary gonadotropic hormones, the patient is usually dwarfed and there is complete failure of sexual development with infantile breasts and genitalia. The more common type of congenital primary ovarian failure is the eunuchoid type, where the ovarian failure is thought to occur near the time of puberty. In these cases, childhood sexual organs persist, the breasts remain of neutral type, pubic hair is scanty, and the patient is usually tall and thin with a narrow pelvis. Because of delay in epiphyseal closure, the long bones grow to abnormal lengths, resulting in an increase span over height and increased symphysis-sole measurement over symphysis crown distance. Sterility is absolute. In acquired ovarian insufficiency later in life, the stature is normal, but regressive and atrophic alterations occur in the genital tract and breast, and there is a tendency to gain weight. These patients will show an excess of gonadotropic hormone in the urine due to lack or absence of the inhibiting influence of estrogen upon the anterior hypophysis. This excess is important in differentiating primary and secondary ovarian failure (pituitary deficiency) (Table I). Rare ovarian tumors such as arrhenoblastoma and adrenal rest tumor produce hypoestrogenism, because of the excessive production of androgen, and are characterized by masculine changes, amenorrhea, atrophy of the breasts, uterus, and vagina, enlargement of the clitoris, widespread hypertrichosis, a deepening of the voice, and loss of feminine curves. It is well to keep in mind that excessive and unjustified androgen therapy may also result in virilization. Another rare tumor that may be associated with amenorrhea is the seminoma or dysgerminoma, which is of embryonal origin. It is rather commonly found in pseudohermaphrodites.

Thyroid

Both hypothyroidism and hyperthyroidism may produce amenorrhea. The type of menstrual irregularity that occurs with either thyroid state is not constant. The thyroid gland plays no direct role in the mechanism of the menstrual function, but it may interfere with menstrual function indirectly by virtue of its influences on the structure and physiology of the hypophysis or ovaries. Thyroxin normally increases the oxidative processes in the cells of every organ, consequently the amenorrhea of marked hypothyroidism may be merely a "manifestation of insufficient cellular activity of the body as a whole, including the hormone-producing cells of the ovaries and pituitary gland"⁵. The amenorrhea of severe hyperthyroidism may be the result of the profound toxemia on the ovaries. Experimental evidence has shown that excessive thyroid function inhibits both gonadotropic and estrogen hormones,² and also hastens the elimination of estrogen.⁵ A pituitary hypothyroidism is occasionally encountered, and it is characterized by a stubborn amenorrhea, an absence of severe depression and myxedema despite a very low basal metabolic rate, and a resistance to thyroid therapy. This condition responds readily, however, to the

administration of thyrotropic hormone of the anterior pituitary.

Adrenal

Hyperplasia of the adrenal cortex and certain cortical tumors produce a hypersecretion of diverse cortical steroids, chiefly androgens, which in the female results in masculinization. This syndrome is known as the adrenocortical syndrome, adrenal virilism, or adrenogenitalism and is characterized by complete reversal of the sex characteristics to the masculine type. The most striking changes are amenorrhea, hirsutism, vocal changes, atrophy of the internal genitals, and hypertrophy of the clitoris. These changes are probably due both to the neutralizing or repressing of the female sex hormones and to the direct masculinizing effect of the androgens. Hypertension, hyperglycemia, and often obesity are present. Ovarian arrhenoblastoma and pituitary basophilism must be differentiated (Table II).

Addison's disease, which is the result of chronic cortical failure, may also cause amenorrhea and is characterized by hypotension, muscular wasting and weakness, and characteristic pigmentation.

Pancreas

Amenorrhea is seen not infrequently in patients with diabetes mellitus. Conversely, insulin is said to be a depressant of ovarian function and its prolonged use may result in amenorrhea.² Estrogen therapy is said to reduce the insulin requirements of pre- and postmenopausal women.⁹

Obesity

Scanty bleeding and amenorrhea are common in obese women. The differential diagnosis of simple obesity and that associated with endocrine disease may not be easy. Freed³ states that 99 per cent of amenorrhea due to obesity is the simple non-endocrine alimentary type, while Fluhmann² thinks that in most cases it is likely that both the obesity and amenorrhea result from a common cause. Anyway, according to Hamblen, simple obesity may impair the health and embarrass the gynecic functions of the adult, and obesity in childhood should "always be regarded as pathologic per se."⁶

Nutritional

Debilitating Diseases and Intoxications

Amenorrhea is commonly seen in malnutrition, wasting diseases, and intoxications such as long standing morphine or alcohol addiction, and may be the result of inadequate or improper ovary and pituitary nourishment; or the amenorrhea may be of a hyper-estrogenic type as a result of defective hepatic function in the breakdown of estrogens. Apparently, the vitamin B complex plays an important role in this hepatic function, and deficiencies of it may thus reduce the ability of the liver to destroy the normal

amount of estrogen. This results in an elevated estrogen blood level and hyperplastic endometrium. Cirrhosis of the liver and hepatitis may produce amenorrhea on the same basis.

Psychic

Mental Diseases

Emotional disturbances such as shock, fear, anxiety (especially over fear of pregnancy), sexual disharmony, surgical operations, and change of environment, frequently bring about amenorrhea. Marwil¹⁰ reported 100 cases of amenorrhea in healthy, uncomplicated Waves at a naval training station. From vaginal smears, he concluded that there was partial ovarian hypofunction, the result of psychic influences associated with change of habits and the discipline of training. Whitacre and Barrera¹¹ reported that as a result of the war, in 14.8 per cent of the women in the Santo Tomas Internment Camp at Manila amenorrhea developed before there was time for nutritional factors to play a part.

Various mental diseases, especially depressed states, may produce amenorrhea, probably through the psyche. Anorexia Nervosa, which occurs chiefly in young adults following some prolonged emotional conflict, is characterized by early amenorrhea, extreme aversion to eating, epigastric distress, emaciation, weakness, low basal metabolic rate, hypoglycemia, and bradycardia. Some clinicians have termed this a pituitary "blackout"⁵ of psychoneurotic origin. It may be confused with other wasting diseases such as Simmond's disease (Table III).

To explain amenorrhea of psychic origin one must consider that there is a higher power than the dominant pituitary gland in the regulation of menstruation, and that this power is probably the hypothalamus.¹² Histologic endometrial examinations have suggested that sudden shocks may cause an immediate arrest of endometrial development, regardless of its phase, probably by interruption of the release of proper hormones. Fuerstner¹³ speaks of the hypothalamus as "a sort of super sending center of autonomic impulses regulating, among other functions, the menstrual cycle." He states also that "instead of the usual stimulation through endocrine releases, the autonomic impulses may by-pass these and produce a direct effect on the uterine endometrium."

Pathology of Functional Amenorrhea

The pathologic picture may be as diverse as the etiology. The uterus may be normal, enlarged, or small and atrophic with a decreased or reversed uterine-cervical ratio, and the endometrium may appear as proliferative (estrogenic) phase, secretory (progestational) phase, hyperplastic or atrophic. The ovary may vary from a condition of complete or partial atrophy to one of enlargement with retention cysts or tumors. Occasionally, a complete ovarian

cycle may occur during a period of functional amenorrhea, which explains the occasional pregnancy at such a time.

Laboratory diagnostic methods that may be needed in studying cases of amenorrhea are: urine analyses, blood counts, blood chemistry, glucose tolerance tests, basal metabolism, biological pregnancy tests, roentgenograms, endometrial biopsy studies, vaginal smear examinations, and hormonal assays.

Treatment

It is not within the scope of this paper to outline therapy for all the conditions mentioned which may directly or indirectly cause amenorrhea. Obviously, tumors must be removed when feasible, specific diseases such as diabetes, hyperthyroidism and pellagra must be treated accordingly, obese patients must be reduced, and psychotherapy must be instituted when indicated. Discussion of treatment shall be limited to amenorrhea that is functional in the stricter sense of the word, i. e. amenorrhea without obvious endocrine stigmata or other apparent cause.

The belief that functional amenorrhea is accompanied by a long series of untoward symptoms of ill-health is generally held by the laity and even by some doctors. This misconception is often due to failure to recognize that amenorrhea and poor health may result from a common cause. In some, the old superstition still prevails that menstruation is a type of natural purgation and that failure to menstruate results in an accumulation of detrimental poisons in the body. The mere cessation of menstruation is not accompanied by untoward symptoms except under three conditions, according to Fluhmann:²

"1. The amenorrhea may be due to some extraneous factor such as a systemic disease which in itself brings about unfavorable manifestations.

"2. Various psychic changes may result from apprehension and lack of understanding on the part of the patient.

"3. In severe prolonged instances of amenorrhea there may be a total suppression of ovarian function, so that vasomotor and other phenomena of the climacteric make their appearance."

Greenhill¹² is opposed to treating amenorrhea except in young girls who have not begun to menstruate by the time they are 18 years old and in married women who desire children. There is often no reason to treat women with hypomenorrhea and oligomenorrhea, and they are to be considered fortunate in losing only small amounts of blood and being handicapped less by annoying and uncomfortable protective appliances. There are many ways of making women have vaginal bleeding, but the end results insofar as establishing ovulation and normal cycles are generally poor. Cases of infertility, however, should have the benefit of anything in the

armamentarium that has a possibility of restoring fertility.

In simple anxiety cases of amenorrhea, often due to fear of pregnancy, it is safe to attempt induction of menstrual bleeding with prostigmine methylsulfate. There are no ill effects, and pregnancy is not interfered with should it be present. Friedman¹⁴ treated 90 amenorrheic patients and restored menstrual flow in 94.5 per cent of the cases not due to pregnancy, by giving 1 mg. of prostigmine daily for 1 to 3 days. This treatment, however, should be reserved for patients with a previous regular or only slightly irregular cycle.

The value of estrogen therapy has been argued pro and con. In hypoeostrogenic states, vaginal bleeding can be produced by cyclic estrogen therapy; this is estrogen-withdrawal bleeding. By giving diethylstilbestrol 3 mg. or estrone sulfate 3.75 mg. daily for 20 days, bleeding will usually then result after a latent period of 7 to 14 days. If there is no bleeding, the 20 day course of treatment may be resumed after a 10 day rest period. If bleeding occurs, therapy is discontinued and resumed again on the fifth day after the onset of bleeding. Freed³ states that after 3 such courses, 30 per cent of the patients will have normal menses to follow. He describes it as "like shaking the clock to make it start ticking again." Other investigators⁸ put this percentage much lower. It must be remembered, too, that many may spontaneously resume their menses. Estrogens, however, have not been shown to effect spontaneous normal ovarian function, nor to stimulate the pituitary. On the contrary, if given in large doses, estrogens may inhibit the pituitary. Indications for estrogen therapy are aptly put by Hamblen⁶ who writes "even where there is no hope of establishing or restoring the childbearing function, cyclic estrogen therapy may be justified for these reasons:

"1. The cosmetic inelegance of adolescent hypoeostrogenism may be erased.

"2. Abnormal statural growth which is common in adolescent hypoeostrogenism may be corrected.

"3. Genital development commensurate with normal coital function may be effected or restored."

This is substitution therapy, however, and genital regressions may occur when treatment is discontinued. Bickers¹⁵ and Finkler¹⁶ have shown that despite the induction of bleeding by estrogens or estrogens and progesterone, little change occurred in the endometrial pattern. The endometrium is the best index to ovarian function. When estrogen therapy is to be instituted it is much more preferable to use oral administration. Oral therapy does not lend itself to the "shot" habit, is more convenient, and maintains a more constant estrogen level. Synthetic estrogens (stilbestrol and hexestrol) are more economical and equally good or better. Animal experiments have

demonstrated that synthetic estrogens are also inactivated in the liver, but to a lesser extent or slower than natural estrogens.¹⁷ Cinberg¹⁸ reported the resumption of menses in 41 per cent of women with secondary amenorrhea after courses of oral cyclic therapy of estrogens and progesterone, but with parental therapy spontaneous resumption of vaginal bleeding occurred in only a few isolated cases.

To simulate further the normal cycle in substitution cyclic therapy, 10 mg. of progesterone may be given orally (pranone) from days 14 to 28 in the cycle, while the estrogens are being given from days 1 to 20. The withdrawal of progesterone itself will cause uterine bleeding when the endometrium is primed by estrogens. This fact constitutes the basis for a test for the presence of estrogens in doubtful cases—the so-called “medical D and C.” By administering progesterone alone for 10 to 14 days in sufficient amounts, withdrawal will result in bleeding in 2 to 5 days, provided there is enough estrogen in the body to prime the endometrium. Failure of progesterone withdrawal bleeding indicates hypoerogenism. If for some reason it is desirable or imperative to obtain uterine bleeding as quickly as possible in a functional amenorrhea case of fairly long standing, a combination of estradiol benzoate 2.5 mg. and progesterone 12.5 mg. may be injected on 2 consecutive days. Finkler¹⁶ produced bleeding in 25 of 31 such instances.

Pituitary gonadotropic substances would constitute the theoretically specific treatment for amenorrhea which is of secondary ovarian failure. In primary ovarian failure, there is already present an excess of gonadotropic hormones in the blood and urine doing their best to stimulate ovarian activity. Gonadotropic therapy in these cases is worthless because ovaries which are incapable of responding to normal intrinsic pituitary stimuli cannot be restored to normal function. In amenorrhea of pituitary failure various types of gonadotropic substances have been used in an attempt to supply the missing ovarian stimulus directly or by stimulating the hypophysis to do so. Chorionic gonadotropin alone is now considered useless in amenorrhea therapy, as it is incapable of stimulating either the pituitary or the ovaries of the human.⁶ Available pituitary extracts are weak and expensive because the anterior hypophysis actually stores very little of the gonadotropic hormones. More recently, a combination of chorionic gonadotropin and anterior pituitary extract (Synapoidin, Parke, Davis & Co.) has given promise of showing more clinical value. According to Hamblen,⁶ the most practical approach to amenorrhea from pituitary failure includes periodic tests of one-two cyclic gonadotropic therapy after normal genital function has been induced or restored by cyclic estrogen-progesterone therapy. His dosage schedule is 400 I. U. of equine gonadotropin (pregnant mare serum), intramuscularly, daily for 10 days followed by 500 I. U. of chorionic gonadotropin for 10 days. If there is no response, after a 5

weeks' rest period, the cycle is repeated using 1000 I. U. as daily doses. A third and last cycle may be tried if necessary, after another 5 weeks' rest period, using dosages of 1500 I. U. With these larger doses severe reactions often occur, in spite of negative skin tests. Even small amounts of equine gonadotropin should not be given without careful preliminary skin testing because of the presence of horse serum. These gonadotropins are follicle stimulating, but their active ability to cause ovulation is doubtful. Results obtained with this mode of therapy are very likely temporary. Reactions, antibody formation (antigonadotropic?), and almost prohibitive high cost, make this form of substitution therapy impractical. Abarbanel and Leatham¹⁹ recently concluded that clinically, equine gonadotropin proved to be a rather ineffectual stimulant to the abnormally functioning or hypofunctioning ovary as far as the restoration of normal cyclic metabolism and the reappearance of regular menstrual rhythm was concerned. They also felt that the principle of such heterogenous substitution therapy might yield far greater harm than any temporary good.

The underlying principle in cyclic therapy is an attempt to imitate and initiate the normal menstrual cycle by supplying the hormones concerned in their usual sequence. The principle is good; the clinical results are not. Apropos of all substitution therapy, except when definitely indicated and used with complete understanding, may it not be compared to the former worthless use of emmenagogues and oxytocics which merely led to an abnormal uterine hemorrhage?

There are many advocates for low dosage irradiation therapy of the hypophysis and ovaries in amenorrhea in which pelvic pathologic conditions and pregnancy can be definitely ruled out. Mazer and Greenberg²⁰ reported 72 per cent of 92 patients so treated, menstruating normally after a 3 year follow-up. Heilman and Hunter²¹ reported 50 per cent of 40 patients so treated, with resultant regular periods, 8 of which later had children (3 of his patients had had children before the onset of amenorrhea). The mechanism of such therapy is not completely understood, and the boundary line between clinically effective and injurious doses of roentgen rays has not been established. In many species of animals, x-ray treatment may result in monstrosities and deformities, not in the first or second generations, but in later ones. X-ray therapy, however, should probably not be withheld from all women because of these speculative objections. In a selected group, the treatment may be justifiable provided adequate medical treatment has first been tried, and the irradiation is carried out only by a competent roentgenologist.

Dessicated thyroid extract is the one most valuable endocrine agent in the treatment of amenorrhea. This has not yet been proved in the laboratory, and one is apt to resort to such phrases as “nonspecific tissue

tonic" to explain it. Many workers feel that it is of no value and not indicated except in definite hypothyroidism, but if this is true, then the weight of clinical evidence of the value of thyroid therapy would make one doubt the accuracy of present methods of measurement of thyroid function. Even in the presence of a normal basal metabolic rate, desiccated thyroid should be given a clinical trial; it should be prescribed in small amounts, gradually increasing up to clinical tolerance. It is apparent, also, empirically, that thyroid forms a valuable adjunct to other endocrine therapy, and it should be given simultaneously. Thyroid extract has a stimulative effect on cellular function as a whole, including that of the pituitary gland. Both in regard to theoretic considerations and to the clinical results obtained, the principle of physiologic stimulative therapy by means of a nutritionally balanced diet and desiccated thyroid is far more rational and efficacious than various substitution programs.

Summary

- (1) An etiologic classification of amenorrhea derived from Fluhmann and Freed is given.
- (2) The multiplicity of etiologic factors demonstrates that amenorrhea cannot be considered solely as a pelvic disturbance requiring local treatment. It is a symptom which requires extensive investigations as to systemic diseases, endocrine entities, psychic disturbances, malnutrition, and an unfavorable social or occupational environment.
- (3) Tables are presented outlining differential

- diagnoses of certain endocrine entities.
- (4) A search must be made for the etiologic factor in order to determine the prognosis and to institute proper therapy.
- (5) Treatments of functional amenorrhea, unassociated with causative factors, are discussed.
- (6) Reassurance, adequate diet, and desiccated thyroid are the most valuable therapeutic agents.

Table I

Differential Diagnosis of Primary and Secondary Ovarian Failure⁵

	Primary Ovarian Failure	Pituitary Deficiency
Amenorrhea	Present	Present
Genital Atrophy	Present	Present
Estrogen Level	Low	Low
Body Configuration	Usually thin	Usually Obese
Dysmenorrhea	Present	Absent
Dyspareunia	Present	Absent
Emotional Reactions	Exaggerated	Slight
Hypertrichosis	Absent	Usually present
Headache	Uncommon	Common
Visual fields	Normal	Minor defects
Pituitary gonadotropin levels	High	Low
Basal metabolism	Normal	Slightly decreased
Sugar tolerance	Normal	Increased

Table II

Differential Diagnosis of Virilizing Syndromes^{5 6}

	Pituitary Basophilism	Adrenal Virilism	Arrhenoblastoma
Amenorrhea	Present	Present	Present
Hypertrichosis	Present	Present	Present
Atrophy of internal generative organs	Present	Present	Present
Obesity	Face and trunk	Face and trunk	Usually absent
Hypertension	Present	Present	Absent
Hyperglycemia	Present	Present	Absent
Purple striae, ecchymoses, and acne	Common	Common	Absent
Osteoporosis	Common	Common	Absent
Palpable ovarian mass	Absent	Absent	Usually present
Palpable adrenal mass or abnormal pyelogram	Absent	Often present	Absent
Clitoris	Not enlarged	Hypertrophied	Hypertrophied
Excess Androgens in the urine	Absent	Present	Absent
General physical status	Weak	Strong	Strong
Epiphyseal union in childhood	Retarded	Precocious	Precocious

Table III
Differential Diagnosis of Simmond's Disease and
Anorexia Nervosa⁶

	Simmond's Disease	Anorexia Nervosa
Amenorrhea	Present 82%	Present 100%
Cachexia	Present 65%	Present 75%
Asthenia	Present 90%	Present 55%
Hypotension	Present	Present
Hypometabolism	Present	Present
Postpartum onset	42%	0%
Alterations in sella Turcica	43%	0%
Loss or absence of axillary and pubic hair	80%	15%
Premature senility	45%	5%
Atrophy of breasts	21%	0%
Pallor	48%	0%
Eosinophilia averages	6.3%	0.6%
Reaction to therapy	6%	85%
Mortality	97%	0%

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REPORT OF THE MEMORIAL COMMITTEE ANNUAL SESSION

May 1, 1946

Myrtle Beach, S. C.

"Our Annual Meeting never fails to teach us at least one lesson. The art whose province it is to heal and to save cannot protect its own ranks from inroads of disease and the waste of the Destroyer.

"Twenty-three of our associates have been taken from us since our last Anniversary. Most of them followed their calling in the villages or towns that lie among the hills or along the inland streams. Only those who have lived the kindly, mutually dependent life of the country, can tell how near the physician, who is the main reliance in sickness, of all the families throughout a thinly settled region comes to the hearts of the people among whom he labors, how they value him while living, how they cherish his memory when dead. For these friends of ours who have gone before, there is now no more toil; they start from their slumbers no more at the cry of pain; they sally forth no more into the storms; they ride no longer over the lonely roads that knew them so well; their wheels are rusting on their axles or rolling with other burdens; their watchful eyes are closed to all sorrows they lived to soothe. Not one of these was famous in the great world; some were almost unknown beyond their own immediate circle. But they have left behind them that loving remembrance which is better than fame, and if their epitaphs are chiselled briefly in stone, they are written at full length on living tablets in a thousand homes to which they carried their ever-welcome aid and sympathy.

"Let us hope that our dead have at last found that rest which neither summer nor winter, nor day nor night, had granted to their unending earthly labors."

—*Oliver Wendell Holmes*

MEMBERS OF THE S. C. MEDICAL ASSOCIATION WHO HAVE DIED SINCE THE PAST ANNUAL MEETING

Dr. Robert H. Ariail
Dr. G. C. Bolin
Dr. L. C. Brooker
Dr. C. H. Burton
Dr. E. R. Donnalld
Dr. J. L. Fennell
Dr. C. T. J. Giles
Dr. John R. Harrison
Dr. B. A. Henry
Dr. David B. Jackson
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Dr. D. S. Keisler
Dr. O. W. Leonard
Dr. W. S. Lynch
Dr. Robert Lane McCrady
Dr. J. E. Massey
Dr. B. M. Montgomery
Dr. Frank L. Parker
Dr. Henry L. Scarborough
Dr. Robert Boyd Stith, Sr.
Dr. L. M. Stokes
Dr. J. B. Workman
Dr. John P. Young

Laurens, S. C.
Orangeburg, S. C.
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Iva, S. C.
Honea Path, S. C.
Waterloo, S. C.
Greenville, S. C.
Greer, S. C.
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 Office of Publication: (In care of the Editor)
 Subscription Price

 Florence, S. C.
 \$3.00 per Year

AUGUST, 1946

CATCHING UP

We doubt whether there has ever been as great a demand for post-graduate study, a greater desire for "catching up" with what is new in the various fields of medicine, as there is today. Those physicians who have been in military service have lost contact with many phases of medical practice and realize the necessity for being brought up to date in these subjects, the physician in civilian practice has been so busy with patients that he has had little time for reading and study. Medical centers are being swamped with requests for special courses, for residencies and fellowships in various specialties.

It has occurred to us that the county medical societies could render a highly valuable service in helping to fill this widespread demand for "catching up." We would suggest that a part of each scientific meeting be allotted to some speaker who will briefly review "what is new" in a particular field. We realize that sufficient time could not be given for a comprehensive review of the subject, but a mere mention of the highlights would at least give those in the audience opportunity to sense the trend. Later, in their own offices or homes they could read and study further for themselves. We pass the idea on for what it is worth to that committee in each county society which is responsible for preparing the scientific programs for the coming year.

THE ANNUAL DIRECTORY

In 1942 we began to publish an annual directory of the members of the Association and we plan to present the 1946 edition in the next issue of this Journal. As usual, the list of the members of the Association will be presented alphabetically and also according to towns.

It has been interesting to note the reception which was given this endeavor. At first, there was little comment but now scarcely a week goes by without a request for a copy of the directory. Physicians returning to practice, physicians opening up new practices, secretaries of county medical societies, offi-

cers of the Association, and organizations in this and other states have found that the directory affords an excellent mailing list and also a quick reference for locating a given individual.

As in the past, the names in the directory will be limited to those physicians in the state who are members in good standing of the Association. We hope that any reader of this statement who has not sent in his dues for this year will take the hint.

Extra copies of the Directory, separate from the Journal, will be available for those who desire them. A charge of twenty-five cents will be made to cover the actual cost of printing. It is requested that orders be placed before September first so that a sufficient number of copies will be printed.

PROGRESS OF THE SOUTH CAROLINA CHILD HEALTH STUDY

The South Carolina Pediatric Society has been carrying on a Child Health Study throughout the State for the past three months. This Study is part of a nation-wide Study being sponsored by the American Academy of Pediatrics and its purpose is to determine what are the health needs of the children of this country and what facilities are available to meet these needs. At the State Medical Association Meeting in May, the Child Health Study was approved unanimously by the Medical Association's House of Delegates.

During the last two weeks of June, each and every physician in South Carolina was mailed a questionnaire, the purpose of which was to obtain information as to the individual's training, type of practice, number of hours spent in private practice, school health services and other activities such as teaching. The last question asked data on the individual physician's work load for one specific day of the week. This question was worded so that one could obtain the approximate amount of services given to children by each practicing physician—whether he did general practice or a specialty.

Up to July 2nd, 1946, approximately 38% of the doctors of South Carolina had returned their completed questionnaires. It is noteworthy that in a similar Study carried out in North Carolina, over 53% of the physicians of that State returned their questionnaires, thus indicating a tremendous amount of interest in Child Health Care. It is hoped that the physicians of South Carolina will support this tremendous undertaking that the pediatricians of the State are attempting to do by furnishing them with information as to the medical care that is being given the children of South Carolina.

Although South Carolina stands rather low in the health record of this nation, we are being offered an opportunity to stand high on a progressive effort to find out why and how to raise that record for the children of our State.

HENRY W. MOORE, M.D.,
Executive Secretary.

THE SAN FRANCISCO CONVENTION

(One man's impressions)

On previous occasions I have described my trips to annual meetings of the A.M.A. in the form of a travelogue. To avoid monotony, I shall make my presentation this time in another form.

Hitchhiking By Air

Having been careful to make my plane reservations well in advance, I thought there was little chance for trouble. How little did I know about travel difficulties today.

Leaving Florence bright and early Saturday morning, I arrived in Columbia and reported to the ticket office to check in—and was greeted with the information that the plane was two hours late. At the appointed time, I went out to the field and was soon joined by Dr. William Weston, Sr. Another two hours went before the plane finally came in and we boarded. Four hours late and our schedule called for only one half hour leeway in Atlanta!

When we arrived in Atlanta we found the plane on which we were scheduled to ride had left and with it our reservations. There was one seat available on a second plane and Dr. Weston took this upon my insistence.

Four hours later they called my name. They told me there was a seat available to Birmingham and that they thought I could go on into Dallas. On arrival in Birmingham I found that the agent's intent was good—but there was no space. So I ran up to a hotel for the night. At eight o'clock Sunday morning I found a seat and went to Dallas.

Dallas proved to be a gathering point for travellers—all wanting to go somewhere with too few planes to carry them. And Dallas is hot, the airport small and the seats hard. After eight hours of this

atmosphere, I finally found a seat on a four engined plane and headed for Los Angeles. Over a thousand miles with only one stop—and that at Tucson. The plane rode easily, the chairs were soft and sleep was in order.

Came Los Angeles and another four-hour hangover. And finally, San Francisco—twenty-three hours later than originally planned. I sincerely regretted the delay since I was scheduled to appear on the program of the Conference of Presidents and other state association officers on Sunday afternoon. But I had sent a copy of my paper ahead of time and this was read for me by the secretary of another association, so perhaps it worked out all right after all.

The moral of this little story is—travel is still uncertain and there is still many a slip between what your ticket promises and what you get.

The House of Delegates

As usual, the meeting of the House of Delegates was intensely interesting to an observer. The members meant business. They were usually in their seats on time and stayed there through each session. The Reference Committees gave time for discussion and the reports were fair.

Our delegate, Hugh Smith, served on the reference committee which is probably the most important—the one on Medical Service and Public Relations. There was much to be considered and digested and the committee met both long and often. I sat with Hugh during the last session of the House of Delegates and he looked like a little vacation would be most welcome.

The most far reaching action of the House of Delegates consisted in adopting a recommendation from the Board of Trustees relative to some fundamental changes in the setup of the executive offices of the Association. Based upon a detailed study made by Rich & Associates (a public relations concern) the recommendation called for the establishment of three distinct departments in the headquarters office. First, there is to be a scientific editorial department which will interpret to the public, through Hygeia and through news releases, the advances and achievements of scientific medicine. This department will be under Dr. Morris Fischbein. A second department will deal with medical economics and will be headed by an economist. The third department will be devoted to public relations, headed by an expert in this field. The last two departments will be under the general supervision of Dr. George Lull, Secretary and General Manager of the Association.

Another action of the House of Delegates was to make provisions for two meetings a year—the second meeting will be held in Chicago in November.

Various other important actions of the House of Delegates will be discussed by our delegate, Hugh Smith, in his special report.

The new President-Elect of the Association is Dr.

Olin West, and the 1948 session will be held in Atlantic City.

The Scientific Sessions

From all indications, the scientific sessions were of high calibre and were well attended, and I was able to attend some of them between sessions of the House of Delegates. I sat in on sessions of the Section on Pediatrics and also on a part of a session of the Section on General Practice of which our neighbor, Wingate Johnson of Winston-Salem, was Chairman. I did not have the opportunity of seeing Warren White in action as Secretary of the Section on Orthopedics, but understand that he did his job efficiently and well.

The most interesting session I attended was on the last day and was presented jointly by the Sections on Internal Medicine and Experimental Medicine. It might be called the 1946 model of Information Please. Nine experts sat on the platform with Dr. James Paullin of Atlanta as moderator. Each participant represented a particular field of medicine (cardiology, endocrinology, cancer, gastroenterology, etc.) and was given five minutes in which to discuss "What's New" in his particular line of work. This was followed by a general discussion with questions from the audience. Such a program at one of our South Carolina annual sessions should be worth trying.

Scientific and Commercial Exhibits

The scientific and commercial exhibits continue to be one of the fine features of the meeting. Here one may spend hours looking, studying, browsing, and chatting. And finally, when one becomes weary of imbibing knowledge, there are free offerings of Coca-Cola, pineapple juice, and instantaneous coffee.

San Francisco

Despite warnings and predictions as to what the weather man might do in San Francisco in July, the weather could not have been more pleasant.

The most striking thing about San Francisco to me was the wholehearted cordiality of its citizens.

This is in marked contrast to the situation in some of our large cities in the east. The California physicians outdid themselves in making those at the meeting feel at home. And this was no small task since more than seven thousand physicians were registered.

The city itself affords much of interest to the visitor. The seven hills, the waterfront, the two great bridges, Chinatown, night clubs, restaurants, etc., all blend to make San Francisco a mecca for tourists. Needless to say, the visiting physicians made good use of their spare time. In company with a San Francisco physician I made an enjoyable tour of the city one evening. Another evening, Lee Milford of Clemson, my brother, and I visited a Swedish restaurant with its famous smorgasbord.

S. C. Physicians

The following physicians from South Carolina were in attendance: R. L. Crawford of Lancaster, W. H. Fold of Spartanburg, Francis B. Johnson of Charleston, Katherine MacInnis of Columbia, Lee Milford of Clemson, Everett Poole of Greenville, Hugh Smith of Greenville, Warren White of Greenville, William Weston of Columbia, John B. Nettles of Columbia.

Salt Lake City

Since a trip to the west is the event of a decade I decided to return by way of Salt Lake City to visit my brother who is Professor of Surgery at the University of Utah School of Medicine. I doubt that there is a more beautiful city in this country than Salt Lake City and the twenty-four hours spent there were most enjoyable.

Back Home

The trip back was made without too much difficulty. Twenty-four hours after leaving Salt Lake City I stepped off the plane in Columbia. What would the early pioneers have thought of such a trip!

Back to Florence to find patients waiting and work stacked high on the desk.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

MEDICAL PREPAYMENT PLAN NEXT

Two of the objectives outlined in the Ten Point Program having been substantially accomplished, with the procuring of enabling legislation for the Blue Cross Plan and perfecting of that organization, and with the passage of the law providing for a statewide hospital survey under the direction of the South Carolina Research, Planning and Development Commission, it is apparent that the time has arrived for further attention to the organization and setting up for operation of a non-profit medical service plan in this state. Both the projects first mentioned, so far as the doctors were concerned, were preliminary to the third, which is an activity deserving of their

most genuine interest and effort.

The subject has been discussed in this column repeatedly since our duties with the state association were assumed, to such an extent that at times we have feared lest our readers may have been bored with the repetition of the theme. But we do not feel that any apology is necessary and offer none. It was recognized some years ago by many doctors as well as laymen, that such a step is desirable and proper, but a great deal of education on the subject, within the profession, was necessary. Thought, planning and efforts by the doctors throughout the nation, including those in South Carolina, crystallized in a conference, and formation of a plan, for nationwide

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* *Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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development of prepayment medical care plans last November.

In a brochure published within the past few weeks by the Council on Medical Service and Public Relations of the American Medical Association, there is a complete digest of the existing prepayment medical care plans, and plans offering prepayment medical care benefits in connection with Blue Cross Plans, whether on a service or indemnity basis, and without limitation to those plans which have received approval by state or other medical associations. This should be a source of valuable information and is being carefully studied. Our file previous to its receipt was already thick with material on the subject, including specimen contracts, copies of enabling legislation from the various states, and a quantity of material bearing upon the plans.

According to the booklet, at the end of 1945 there were voluntary prepayment plans supervised by state and county medical societies, operating in 25 states, and plans formed and being prepared for operation in eight others. Although the total number of people enrolled in 1945 was not large compared with the whole population of the country, it included an increase of 100% over that for 1944. Following the data on each of the plans in existence or in process of organization, there is a list of those states, including South Carolina, wherein plans are not yet formed or are in the process of organization, and the comment under South Carolina is that here "a committee of the state medical association is studying the problem of enabling legislation." It should be our objective to have such proposed enabling legislation prepared for presentation to the General Assembly when its next session convenes in January, 1947. To do that, there must be the approval of Council and the interest and endorsement of the idea by the members of the association, and in order to secure the enactment of the legislation into law, there will be required, in all probability, the active cooperation and effort of the entire organization.

The principles and progress of prepaid medical care plans was the subject of a news article by one of the Associated Press feature writers, with a Chicago date-line on June 24th. It was based evidently upon the brochure to which we have referred—certainly from the information included therein. It pointed out the differences between the voluntary prepayment plan and that proposed by the President of the United States and embodied in the Wagner-Murray-Dingell Bill. The forces sponsoring the latter dangerous measure have again, it appears, been turned back, but once more the respite is only temporary. Now is the time for active, aggressive, constructive action by the doctors. Not defense alone, but the counter-attack, will win the ultimate victory, if it is won.

LOAN FUNDS FOR MEDICAL STUDENTS

The time is also ripe for further effort toward

another objective outlined in the Ten Point Program. Through the efforts of this Association and the splendid work of the Committee of Seventeen, the first step toward extension and improvement of medical and nursing education in South Carolina has been accomplished with the securing of the appropriation of adequate funds for the expansion of the plant and facilities of the medical college.

Another sub-division of the same "Point" in our program (#9) is expressed as follows: "To promote the establishment of a loan fund whereby worthy young men and women of the state who are financially unable to meet the strain of a medical education may be able to secure aid."

With the existing facilities in Charleston, the usual difficulty in the past has been in selection from the large number of applicants those most apt to make profitable use of the opportunity extended by their admission to the college. With the expansion which will be possible under the new program, the facilities can be greatly enlarged. The number of students that can be accommodated may be increased. It should be possible to aid deserving young men and women who are ambitious and who have the necessary talent and ambition, but who may be short on funds. If scholarships and loan funds are established by the profession, they should be made available to applicants upon conditions such as would insure their practice at least for a limited period, in areas where more medical service is needed, and there are such areas in South Carolina.

A few days ago we received an inquiry from a lawyer in this state for information to enable him to advise one of his clients who was considering the possibility of making a provision in his will, for a scholarship or loan fund, through the Medical Association. We have no idea whether the client was a physician or a layman, but the incident illustrates the recognition by individuals, either within or without the medical profession, of the opportunity for service to deserving young men and women in this respect, and likewise their recognition of organized medicine in South Carolina as an appropriate channel through which to operate.

It is our belief that, along with the establishment of a medical service plan, this should be one of our principal objectives for concentrated attention within the next few months.

If the medical profession in South Carolina really and genuinely wishes to take a progressive step toward increasing medical care and making it available in rural and other areas where the service is not now sufficient, this is one method of approach which can certainly be developed to the advantage of all concerned. Its accomplishment will not solve the problem, but it will be a step in the right direction, and a solution will never be reached in one single effort. It must come as the result of a number

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of efforts, properly organized, directed and coordinated.

RURAL MEDICAL CARE

To a state like South Carolina, with its large proportion of rural population, the first national conference on rural health sponsored by the American Medical Association and held in Chicago on March 30, 1946, should be of more than passing interest. The official recognition by the heads of the great organization of the medical profession that there exist problems peculiar to the rural areas, and which need attention through media distinguished from those employed with regard to other problems involving the profession, is significant. It serves to underscore the expressions contained in the program of this state association with respect to the need for improvement of medical care in our rural areas.

The conference was attended by Dr. W. L. Pressley of Due West, and Dr. A. W. Browning of Elloree, as delegates from the South Carolina Medical Association, both general practitioners who have served untiringly and well, large practices principally in two of the smaller communities and their adjoining rural areas of our state. Their choice by Council as the delegates to this particular conference, was a happy one. None more representative of the best in physicians serving this type of practice could have been selected.

Along with many of the other delegates, Dr. Browning made a statement to the conference regarding the situation in South Carolina, which was reported as follows in the Journal of the American Medical Association (page 560) of June 8th:

"We have good roads, schools and easily accessible hospitals. Our splendid state board of health is doing good work. Every county has a county officer and nurses. We have in our county the tuberculosis examination for schools, x-ray units in the county and x-ray at the tricounty examination. We have clinics there every week and in two or three towns every week. We have been trying to get a medical college in Charleston for years. Last June the legislature passed the bill for one and one-half millions dollars for a doctors' hospital and also gave us two and one-half million dollars for a survey of the state and for medical centers if needed. I don't know any one in my section who can't get medical care or hospital care when needed. We have a publicity man to watch out for our interests and have a permanent committee, one from each district, to watch the political affairs in our state. We have Blue Cross insurance passed by the legislature and are trying to bring it into effect. We need more hospital beds, hospitals and small medical centers. We are thinking of subsidizing some students while at South Carolina Medical College at Charleston to serve two years in outlying places, also Negroes, as Virginia is doing, at the college in Nashville, Tenn.

We believe in the American Medical Association plan of approved insurance, prepayment hospital and health insurance such as Blue Cross. We are having meetings all over the state with speakers discussing the Wagner-Murray-Dingell bill."

Dr. F. S. Crockett of Indiana, who has been prominent in the activities of the national organization for many years and is generally to be found in attendance at the various conferences in Chicago, opened the meeting by a statement of the purpose for which it was held, and this, he said was "to seek improvement in rural medical services." Quoting Dr. Crockett further, "Rural medical service is more than having a doctor in the community. Good housing, warm clothing and suitable diet, together with adequate health education, are important factors in the maintenance of rural health. The problem is economic and social, as well as professional. . . . Attracting and retaining well-equipped doctors such as returning veterans and recent graduates to areas some distance from medical centers, will be helped by what the doctors and interested farm groups do here and carry back to their home states.

"The problem cannot be solved on a national level. It must be worked out in the community where the need resides. . . . One of the first things to be done is to find out where medical service is lacking. Some states have made surveys of their rural and urban medical facilities. Committees of state medical societies should join actively with their comparable farmers' group committees in identifying themselves with existing state (health) councils or inspiring the creation of such organizations where not now existing.

* * *

"Providing plans for the payment of good medical and hospital care is another part of our problem. It is hoped that in all our states the medical profession will sponsor plans to aid those who find it difficult to pay for catastrophic illnesses."

Dr. Crockett concluded his remarks with these words: "Medical care of our farm people is a nationwide problem which can best be solved on a state and county basis. This is your opportunity to do a constructive job in your own home states."

An interesting and heartening fact about the attitude of the rural population of South Carolina and, we daresay the same is true of the population in other states similarly situated, is that we find among them no appreciable sentiment toward putting medicine and the administration of medical service on a political basis or into the hands of the government in any form. While probably the people in the rural areas as a whole throughout the nation are those by whom medical service is obtained with the greatest difficulty and sometimes at the highest cost, we think it is safe to say that no element of the population served by physicians is more loyal to

the prevailing form of practice and more sympathetic with the physician and more appreciative of his efforts when expended on their behalf.

This is not an accident. There may be other reasons, but two are certainly of great importance. First, there is no more independent and self-reliant soul in the country than the genuine dirt farmer, who is not accustomed to being hemmed in by the physical presence and the limitations imposed by exercise of the rights of other people as is the city dweller. He has always enjoyed a certain freedom and independence which is not available to many people living in the centers of population. He does not take to government control and regimentation of his life and business affairs as do some others who have grown accustomed to and have come to accept these things through the force of circumstance. The other reason which occurs to us is that the average farmer does not easily forget his personal relationships and there is still alive within most of them the feeling of appreciation, fellowship and respect for the doctor, built up through decades of loyal service in all seasons, and at all hours of the day and night.

And yet, perhaps the greatest actual shortage of available medical service, the most genuine need for improvement along this line, exists in the rural areas. Bearing in mind the feeling which still exists toward the physicians, the loyalty which can yet be cultivated and maintained, there is, as Dr. Crockett indicates, a genuine responsibility and obligation on the part of organized medicine to help in working out some form of solution of the problems presented by the need for medical care in rural areas. What the solution is, we are not prepared to say. The purpose of these remarks is to call the matter again to the attention of the thinkers within the profession in the state, to emphasize the fact that the existence of the problem is recognized by the highest authorities in organized medicine, and with the hope of stimulating suggestions from any source whatever of means by which the need can be met, the people served, and the interests of the profession protected.

NEW PROVISIONS FOR MATERNAL AND CHILD HEALTH SERVICES

In this column last month reference was made to the pending hearings on the Maternal and Child Health Bill before the Senate Committee on Education and Labor. As a result of the hearings and the attitude of the Committee, the bill was not reported out, but on the contrary, by unanimous consent, there was introduced in the Senate on July 15th by Senator Pepper for himself and Senator Taft, a joint resolution designed to take the place of the Pepper Bill previously under consideration.

This joint resolution (S.J. Res. 177) was read twice and referred to the Committee on Finance. Coming as it does, with the support of the Committee on Education and Labor, it will probably be adopted by both Houses without much delay.

By this step, the effort to extend maternal and child health services universally throughout the country along the lines contemplated by the Pepper Bill, apparently is abandoned, at least for the time being, and the advocates of such extension content themselves with an increase of the appropriations which have already been provided in the Social Security Act for work in connection with maternal and child health care.

The Joint Resolution proposes to amend Title V of the Social Security Act by increasing the annual appropriation for promoting the health of mothers and children, especially in rural areas and those suffering from severe economic distress, from \$5,820,000 to \$15,000,000, and the allotment from this amount to each state of \$50,000 annually, instead of \$20,000 as heretofore, the balance of the \$15,000,000 to be divided among the states in accordance with the financial need of each, and upon the basis of the proportion of the number of live births in each state to the total number in the United States.

The Resolution would further amend Title V of the Social Security Act by increasing the appropriation for services to crippled children from \$3,870,000 to \$10,000,000 annually and would provide for the allotment of this amount as follows: \$40,000 to each

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state, instead of \$20,000 as heretofore, and the balance for distribution among the states according to the number of crippled children in each state needing the services contemplated in the Social Security Act.

Finally, the Resolution would increase the appropriation for Child Welfare Services from \$1,510,000 annually to \$5,000,000, of which \$30,000 would be allotted to each state, and the balance on the basis of plans taking into consideration primarily the proportion of the rural population of each to the total rural population of the United States. The sum of \$1,500,000 per year is authorized for all necessary expenses of the Federal Security Agency in administering the provisions of the title of the Social Security Act, including the provisions referred to above.

Assuming that the committee at whose direction the Resolution was introduced, and the Finance Committee to which it was referred, have satisfied themselves of the need for the increased appropriations and of their availability without placing undue burden on the economic structure, the Joint Resolution appears to be a sensible and fortunate disposition of the Maternal and Child Health problem, at least temporarily.

----- DEMOCRACY AND MEDICINE*

The United States in a century and a half has become the greatest Nation in the world. George Washington, Benjamin Franklin, James Madison and their associates wrote the prescription in 1787. The treatment these statesmen and students recommended was composed of many ingredients. From a medical standpoint it might qualify as "a gunshot prescription." It contained the rights of the individual, opportunity for all, government by and for the people, freedom of the press, freedom of speech, the right of peaceful assembly, and the right of speedy trial by jury. The vehicle for this prescription contained the inalienable rights of man to life, liberty and the pursuit of happiness and the fact that government exists by the consent of the governed. This prescription of economic vitamins changed the psychology of a group of people whose forbears had been regimented slaves in other countries, and in a century and a half made them leaders of the world.

There are those who would throw away the prescription of democracy and substitute another remedy. The new cure is socialized medicine, political medicine or government medicine, and other federal controls.

That medical care is unavailable to all has never been proven. People do not die in the United States because of lack of medical care. A very small percentage of our population live more than thirty miles from a recognized hospital. The United States has more and better trained doctors and a wider distribu-

tion of medical talent than any other country in the world. Compulsory health insurance will not enhance the situation but will probably make good medical care more difficult to obtain.

Government control of medicine is the virus of national socialism, communism and dictatorship. Bismarck proved this in 1883 when he introduced social security and socialized medicine in Germany and brought forth in our time Hitler, Goering and Goebbels.

Medicine in America today is the best in the world. In our country we find the greatest hospitals, the finest clinics, the best teachers and clinicians, and the outstanding medical schools. Our health statistics are better than those of any other country and our death rate is lower.

Proponents of socialized or federal medicine or compulsory health insurance point to the number of rejections of prospective service men as an argument for government control of medicine in the United States. The rejection percentage of young men and women entering the armed forces was lower in the United States than in Great Britain or Germany, despite government medicine in those countries and the fact that our military requirements were the highest in the world.

Selective Service statistics reveal that 4,217,000 were disqualified for duty with the armed forces. It is, however, not pointed out that 2,707,706 were rejected because of defects which were congenital or over which no type of present-day medical knowledge could prevail! The remaining, 1,509,294, are a group made up of many who refused scientific medical service because of religious or other beliefs; others refused minor surgical procedures because of the fear of induction. It is never pointed out that in this number there were All-American athletes, amateurs and professionals. No one bothers to advise the public that many could have been rendered fit for service by better health education, improved food, housing and living conditions, and other factors having nothing whatever to do with medicine. The great surgeons and the great clinicians and the many faithful and honest general practitioners of the United States of America should not be criticized for conditions over which they have no control!

American medicine is in the front line of defense of the American Way of Life—American Democracy. Medicine is opposing regimentation, not for its own sake but in the interest of business, industry and labor. When American medical men and women become government employees the path is cleared for political control of all endeavor and taps will have been sounded for the Constitution of the United States. It is very likely that when the people of America accept socialized medicine or government-controlled medicine, we are but a short step away from government newspapers, government radio stations, government insurance and centralized control of all endeavor.

There is no room in the United States for old world technics and foreign ideologies. These technics and

*Reprint from Med. Annals of Dist. of Col. (issue of May, 1946) of guest editorial by Dr. E. J. McCormick, Chair, Council on Med. Ser. and Public Relations, AMA.



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ideologies have never been successful. We have been successful in the United States and we have become the greatest Nation in the world, although we are the youngest Nation in the world, because our Government has existed for the people and we have had no faith in the teachings of the old world that people exist for the government.

America has the best of everything in the world today. No other country can offer anything that compares favorably with American labor, industry, engineering, art, education, law, medicine or business. Why risk a change when no need has been demonstrated? It has been said, "Science prospers best when free."

That there is no need for radical change in medicine is proven by the fact that 22,000,000 people have hospitalization insurance, 40,000,000 are insured in whole or in part against accident or illness, and an additional several million are participating in voluntary non-profit prepayment medical plans. These figures will probably double in the next six months. There are at present prepayment plans in 25 states and it is anticipated that such plans will be in operation in 15 additional states within a short period of time. Why endanger Democracy in America and overload the taxpayer when the American Way is extending to all the best to be offered in medicine today?

Let us always remember that our fathers came to America to be free and independent. Security depends upon independence. Let no one encourage dependency in "the land of the free and the home of the brave."

"MALIGNANCY—SHOULD THE PATIENT BE TOLD?"

While glancing through the Scientific Section of one of the medical journals a few days ago, we

chanced upon the above title. It dealt entirely with the professional problem indicated by the words. But it happened to suggest to our wandering thoughts a somewhat different idea.

Despite the concentration of thought upon the subject as a result of the pending proposed legislation in Congress, and the apparent recognition by the organized bodies of the profession that it is time to act, there persists within the profession a very strong sentiment to the effect that all the agitation on the other side is stuff and nonsense, that the doctors are above criticism or reproach and that the people at large are entirely satisfied with the services they receive. The condition resulting from that sentiment may, we think, be likened unto the physical malignant growth which exists sometimes for long periods without being recognized, and scarcely without the knowledge of the individual that it exists. But all the time, day and night, it is getting in its deadly work.

The failure to recognize the existence of the disease throughout the past years has had much to do with the close call which the patient has had in recent months, and from the threat of which it is by no means yet free.

Should the patient be told? If one may presume to assume in this instance the role of the physician (which we are not) and treat the medical profession as laymen (which they are to the rest of the world), it seems to us our duty to state, and to do so repeatedly, what we believe to be the real condition.

Proper regimen of well-directed, progressive, public-spirited positive activity on the part of the profession engaged in private practice, can serve to prolong its life by years, whether or not it can ultimately succeed in preventing the death of that type of practice.

NEWS ITEMS

Dr. J. W. Bell of Greenwood is associated with Dr. Lesesne Smith at Saluda, N. C., during the summer months. Dr. Bell practiced in Greenville before entering the service in 1942.

Dr. M. H. Rourk has returned to Myrtle Beach to re-enter the practice of medicine, associated with his brother, Dr. W. A. Rourk. Dr. Rourk entered the army in May 1942 with the rank of captain. Immediately, he was sent to Moore General Hospital, Swannanoa, N. C., and remained there until June 1944 when he was sent to the Pacific theater. He was discharged from the service recently with the rank of lieutenant colonel.

Dr. John Rainey, Anderson physician, has been made a Fellow of the American College of Physicians. This is a distinct honor and we wish to congratulate Dr. Rainey.

BIRTH ANNOUNCEMENTS

Announcement has been received of the birth of a son to Dr. and Mrs. West Simmons of Greenville. Dr. and Mrs. James Allgood announce the birth

of a daughter on June 25, at Spartanburg General Hospital.

Dr. and Mrs. John M. Pratt of Columbia, have announced the birth of a daughter, Linda Ann, on June 15, at the Columbia Hospital.

The Southern Psychiatric Association will hold its annual session at the Jefferson Hotel in Richmond on October 7 and 8. The last meeting of the Association was held in Nashville in 1941, under the presidency of Dr. Arthur J. Schwenkenberg, of Dallas. The present officers of the Association are:

Whitman C. McConnell, M. D., St. Petersburg, Florida, President.

James K. Hall, M. D., Richmond, Virginia, President Elect.

Edmund McC. Connelly, M. D., New Orleans, Louisiana, Vice President.

Arthur J. Schwenkenberg, M. D., Dallas, Texas, Councillor.

John S. Hickman, M. D., Meridian, Mississippi, Councillor.

Newdigate M. Owensby, M. D., Atlanta, Georgia, Secretary-Treasurer.

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Feinberg, S. M.: Allergy in Practice,
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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To the Editors Greenville News-Piedmont
Greenville, S. C.
To the Editors:

Much publicity has been given lately to the relationship between the removal of tonsils and the development of poliomyelitis. Part of the information has been erroneous and needless worry and inconvenience has been caused a great many people.

The facts are these: There is no evidence to show that poliomyelitis is more apt to occur following the removal of tonsils than at any other time; if it does occur, however, it is more apt to take the more serious form known as the bulbar type; there is no need for alarm in this area, only ten cases of poliomyelitis to

date having occurred this year in South Carolina, a number much less than the usual expectancy; the State Health Department has not and will not in the absence of an epidemic advocate the discontinuance of usual surgical procedures during the summer months; under such circumstances it is not reasonable to deny persons who need it the opportunity of desirable treatment; it would be just as sensible to say one should never use the staircase for fear of falling and breaking his leg.

Please publish these facts and so try to relieve the needless cares and anxieties that have beset many parents in recent weeks.

J. W. Jervey, M. D.

PUBLIC HEALTH NEWS

DDT HOUSE SPRAYING IN SOUTH CAROLINA

A total of 55,582 residences were sprayed with DDT by the State Board of Health and County Health Departments in 23 counties between March 25 and June 28, 1946. Houses sprayed were almost exclusively rural and were located in the most malarious areas of the coastal counties of the state.

Berkeley County supplemented the program of the State Board of Health with sufficient funds to include the entire county. Georgetown and Darlington counties supplemented the program to expand it to larger areas of the counties. The towns of Allendale, Fairfax, St. Matthews, Holly Hill and Walterboro furnished labor sufficient to spray residences in these towns under the supervision of the State Board of Health program.

The State Board of Health has distributed some surplus DDT isomer which has been assigned to it for demonstration purposes to a number of county health departments not included in the regular residual house spraying program. The county health departments used the DDT to demonstrate to people in their counties the method of application and results to be expected from residual DDT spray. It was used largely in various barns, jails and other public buildings, but a few of the counties have organized house spraying programs in areas in which malaria is a problem.

The State Legislature appropriated \$50,000 for the purpose of equipment and DDT to be distributed to the counties for demonstration purposes. Because of shortages in materials, spray cans have been very difficult to obtain. The State Board of Health placed orders for DDT as soon as the appropriation was available, but owing to the great demand for this product, delivery has not yet been made.

NEARLY 200,000 BABIES BORN IN SOUTH CAROLINA DURING 5 YEARS OF WORLD WAR II

Nearly 200,000 babies were born in South Carolina during the war period from December, 1941, through

August, 1945, according to Thomas P. Lesesne, Chief Clerk of the Bureau of Vital Statistics of the State Board of Health.

The exact number of births was 198,661, of which 107,366 were white and 91,295 colored.

S. C. PUBLIC HEALTH HOSPITAL REOPENED

Capacity Limited Temporarily to 50 Patients

The South Carolina Public Health Hospital, located on the Charleston Highway 10 miles south of Columbia, which was closed early in June following a fire that destroyed the kitchen and dining room, reopened on July 8th with a limited capacity of 50 patients.

Dr. C. L. Guyton, Director of the State Board of Health's Division of Venereal Disease Control, has announced that one bus will visit the upper part of the State and one the lower part every two weeks, until such time as the capacity of the hospital can be increased sufficiently to inaugurate full service to every county in the State.

Dr. Guyton said he realized that all county health departments have infectious cases which they are anxious to send to the hospital, but that the number of admissions must be limited to 50 at the present time.

Every effort is being made to procure facilities that will enable the hospital to increase its capacity and all health departments will be notified when this is done.

HOSPITAL SURVEY BEING MADE IN SOUTH CAROLINA

A survey of all health facilities in South Carolina is now under way by the State Research, Planning and Development Board, according to Director Robert M. Cooper.

The survey will determine the scope of all hospitals, both private and public, and will evaluate the sufficiency of them in furnishing adequate hospital,

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clinical, health center, and related services to all people of the state.

In making the survey, the Board is working with the State Hospital Survey Advisory Council created by the recent General Assembly and composed of leaders in the medical, nursing, dental and public health fields. Members of the Council are Dr. Ben F. Wyman, State Health Officer; Dr. George A. Bunch, Director of the State Board of Health's Division of Dental Hygiene, representing the S. C. Dental Association; Dr. Jack Parker, Greenville; Dr. Kenneth M. Lynch, Charleston, and Dr. Julian P. Price, Florence, representing the S. C. Medical Association; Mrs. H. O. Speed, Supervising Nurse, State Board of Health, representing the S. C. Nurses' Association; F. Oliver Bates, Charleston, C. K. Shiro, Spartanburg, and George W. Holman, Rock Hill, representing the State Hospital Association; and Truman V. West, Georgetown, and James G. Halford, Johnston, laymen at large.

The survey is being conducted in anticipation of federal funds being made available for construction of new buildings and the enlargement of present facilities.

Cooper said that the survey does not mean a hospital in each county, "but it does mean that with the availability of federal funds, hospital or health centers will be established so as to serve all the people of the state."

ORTHOPEDIC CAMPS TO OPEN IN POINSETT PARK JULY 31 FOR 4 WEEKS; 384 CRIPPLED CHILDREN EXPECTED TO ATTEND

Swimming, archery, nature study, games, and all the other exciting things youngsters enjoy in camp life are in store for 384 crippled children in South Carolina when they attend the orthopedic camps to be held in beautiful Poinsett Park near Sumter from July 31 to August 31.

For the first time, the camps are to be conducted on a statewide basis with children attending from every county. Arrangements have been made through the cooperation of the State Park Commission to use the Burnt Gin Camp site for white children and the Mill Creek Camp site for negro children, and accommodations will be available for 96 campers each week of the four-week period.

Each camp is on a lake front in Poinsett Park, and each has electricity and running water, eight comfortable cabins for sleeping, and a combination dining-room and recreation hall. While in camp, each child will have the opportunity to participate in swimming, dramatics, arts and crafts, woodwork, archery, music, religious services, nature study, and outdoor and indoor games. At the end of each week a

banquet will be given in honor of the campers.

Miss Emily H. Cate, Physical Therapy Consultant for the State Board of Health, who will be in charge of the camps, has announced that their purpose is "to give handicapped children a sense of security through accomplishment, a sense of belonging through group participation, and to develop a sound attitude for leadership in the future."

Miss Cate's training as a physical therapist and her wide experience well qualify her to direct orthopedic camps. She received her B. S. Degree from Woman's College, University of North Carolina, and her M. S. Degree from the University of South Carolina. She received her certificate in physical therapy from the State University of Iowa Medical School. For seven and a half years she was an associate professor of health and physical education at Texas State College for Women.

Miss Betty H. Payne, a graduate of the University of South Carolina with six years of camp experience, will assist Miss Cate in the administration of the camps. Miss Payne recently returned to Columbia from Hawaii, where she was an assistant director in the USO Overseas Department.

Children who attend the orthopedic camps will be selected by the orthopedist and the orthopedic nurse in each district. Age limits are seven to sixteen. Each child will remain in camp one week, and while there will be under the supervision of trained counselors. The health of the children will be supervised by physicians who have agreed to give their services on designated days throughout the camp period, and by a full staff of professional workers, including nurses and physical therapists. Students from the Bernard Baruch foundation for Physical Medicine of the Virginia Medical College will be sent to the camps for field training.

The camps are made possible by the County Chapters of the National Foundation for Infantile Paralysis, the Crippled Children's Society of South Carolina, and by civic organizations and individuals interested in the welfare of crippled children in the State, and are heartily endorsed by Dr. G. S. T. Peebles, Director of the State Board of Health's Division of Crippled Children, and by all orthopedic surgeons assisting with the crippled children's program.

For the information of organizations and individuals interested in contributing to the South Carolina Orthopedic Camps, Miss Cate has announced that each donation of \$18.00 makes it possible to send one child to a camp for one week. Complete details on how the camps operate can be obtained from Miss Cate or Miss Payne, Division of Crippled Children, State Board of Health, Columbia, or from any County Health Department.

CORRESPONDENCE

To the Editor:

Due to the increased unauthorized sale and use of barbiturates in the past few years it has become necessary for the State Board of Health to take more stringent methods of enforcement of the barbiturate act as set forth in the South Carolina Code of Laws.

Not wishing to create a hardship on anyone dealing legitimately in this class of synthetic drugs and to inform the public, the department is sponsoring an educational program to acquaint everyone of the dangers involved in the indiscriminate use of barbiturates. After a suitable period of such educational and informative programs, rigid enforcement of the law must be carried out.

The first step is to place in the hands of every physician, dentist, pharmacist, and veterinarian, a copy of the statute and request of each of you your support and cooperation in carrying out this program.

The services of Mr. Thomas D. Wyatt, Secretary of the State Board of Pharmacy, have been secured on a part-time basis to assist the State Board of Health with this program. He will probably contact you in the near future and any courtesy shown him will be appreciated.

Yours very truly,
Ben F. Wyman, M.D.,
State Health Officer

SOUTH CAROLINA BARBITURATE LAW

Section 5128-25.

Sale, barter, exchange, giving or possessing of
barbiturates

(1) Prescription necessary-packaging-acts misdemeanor. Any person, firm or corporation selling, bartering, exchanging or giving away any of that general class of synthetic drugs commonly known as barbiturates or their compounds except upon the written prescription of a licensed physician, or the prescription of a person authorized to prescribe narcotic drugs, shall be deemed guilty of a misdemeanor. Any person so dispensing such drugs or their compounds upon such prescription shall upon so dispensing same place same in a container with the name and address of the person prescribing same and the name and address of the person, firm, or corporation dispensing same plainly printed or written thereon, and any person dispensing such drugs or their compounds without so doing shall be deemed guilty of a misdemeanor. Any person other than a licensed physician, licensed dentist, licensed veterinarian or person authorized to prescribe narcotic drugs who shall be found in possession of such synthetic drugs, or their compounds without being in a container upon which the name and address of the person prescribing same and/or without the name and address of the person, firm or corporation dispensing same shall be deemed guilty of a misdemeanor. Provided, that compounds containing not more than one-fourth ($\frac{1}{4}$) of the standard dose of barbituric acid preparation which in combination with active medicinal ingredient or

ingredients the activity of which will preclude the use of the compound to obtain the full effect of the barbituric acid preparation shall be exempt from the provision of this section. "Standard dose," as used herein shall be such as is listed in the "Pharmacopoeia," and if not listed in the "Pharmacopoeia," then as listed in the book "New and Non-Official Remedies," and if not listed in either the "Pharmacopoeia" or the "New and Non-Official Remedies," then a standard dose shall be the average dose recommended by the manufacturer of the compound; provided, further, that nothing herein contained shall prevent the selling, bartering, exchanging, or giving away of barbiturates, or barbiturate compounds, to retail or wholesale druggists, licensed physicians, licensed dentists and licensed veterinarians, without such written prescription; provided, further, that nothing in this section shall be construed to prohibit or limit licensing physicians, licensed dentists, and licensed veterinarians from dispensing barbiturates and barbiturate compounds in the regular course of their practice, except, however, upon any such barbiturate or barbiturate compound being dispensed by a licensed physician, licensed dentist or licensed veterinarian, so much of such barbiturate or barbiturate compound not to be consumed in the presence of such person so dispensing same shall be placed in a container in the manner as provided hereinabove.

(2) Retain prescriptions for 3 years.—Any person, firm or corporation selling, bartering, exchanging or giving away barbiturates or barbiturate compound, upon prescription as herein required, shall retain such prescription for a period of three (3) years from the date of receiving same and exhibit same to the state board of health, or any officer or employee thereof, upon demand.

(3) Enforcement.—It shall be the duty of the state board of health to supervise the enforcement of this section and, in so doing, shall at least once every twelve (12) months require retail and wholesale druggists in this State to submit to it, under oath, statements showing the amount of barbiturates and barbiturate compounds not exempt by this section received and disposed of by them during some specified time. Said statements may also include such other information as said board deems advisable in aiding it to carry out the provisions, purposes and intents of this section. Said board of health, its officers and agents, shall at all times have access to the books and records of such druggist to the end that it may be ascertained that such statements are true. Any person, firm or corporation wilfully refusing to give the required information requested by the state board of health or to give it, its officers and agents, access to their books and records, as above required, shall be deemed guilty of a misdemeanor.

(4) Penalties.—Any person found guilty of a misdemeanor under the provisions of this section shall be punished by a fine not exceeding five hundred (\$500.00) dollars or imprisonment not exceeding eighteen (18) months, or both, in the discretion of the court.

1937 (40) 194; 1939 (41) 390.

BOOK REVIEWS

COMMON AILMENTS OF MAN

Edited by Morris Fishbein, Garden City, New York, 1945.

This book includes a number of articles originally published in "Hygeia" under the editorial supervision of Dr. Fishbein, and purports to expound the essential facts about a number of the usual troubles which afflict the public.

One finds some elements of confusion in looking through the articles, especially those which bear in general on the same subject. For instance, one article states that the ordinary respiratory vaccines are of practically no value, while another states that they are effective in many cases. One says immunity from the ordinary cold lasts about seven weeks, the other says it may last for six months. There seems to be some question of "Which paper d'ya read." One is also a little concerned to find descriptions of methods which are not entirely accepted by the bulk of the medical profession, put down as gospel for the public, such as the use of propylene glycol in influenza or electro-surgery for miscellaneous operations on the nose and even for the tonsils, which are already in sufficient danger from the eager knife without the additional complication of the electric instrument.

One is impressed with the difficulty which seems to hang over many medical writers in their effort to make an intelligible presentation to people who are not familiar with technical terms. Indeed, even in this volume for the public, the medical man may find difficulty in understanding some of the constructions. If all of the articles were modeled on the chapter by our neighbor Wingate Johnson, whose easy and non-technical style stands out above the others, the book would offer a much greater appeal to readers of all descriptions.

Paper shortages are responsible for many badly constructed books, but this one seems to fall even below the pulps in its material. An occasional misspelled word does not add to the attraction. Obviously the editor must have been more concerned with his gin rummy than with the final appearance of this compilation.

J. I. W.

Jackson, C. and Jackson, C. L., eds.: Diseases of the Nose, Throat, and Ear. Phila., Saunders. 1945. \$10.00.

In compiling their book on Ear, Nose and Throat, the authors have done a masterful job of selecting the proper collaborators. Each section is complete but concise and written by an authority on the subject. The section on broncho-esophagology written by the Jacksons occupies about one-half of the volume and is very complete. It offers the student of ear, nose and throat a handy reference for the details of this very intricate subject and is the only book that we know of that offers this happy combination. It is highly recommended to students and physicians interested in this subject.

R. W. H., Jr.

National Health Survey 1935-36 Collected Papers—Government Printing Office 1945.

This is a collection of reprints from the Bulletin of the Public Health Service giving a tremendous amount of reference data derived from a nationwide survey of some years ago. Social and economic factors are considered prominently. Subjects such as medical care, housing, immunizations, educational status, prenatal care and many others are included. Great care was taken to make the innumerable statistical studies authentic—The book is a most valuable source of reference data.

J. I. W.

Major, R. H.: Physical Diagnosis. 3d ed. Phila. and London. W. B. Saunders Co., 1945. \$5.00.

With succeeding editions this book has attained a degree of excellence sufficient to recommend it to medical students and practitioners alike.

W. H. K.

Mitchell-Nelson. TEXTBOOK OF PEDIATRICS: Edited by Waldo E. Nelson, M.D., Professor of Pediatrics, Temple University School of Medicine. Publisher: W. B. Saunders Co., Philadelphia, Pa.

This authoritative work is the successor to the Griffith and Mitchell text, but has been completely rewritten with the collaboration of 49 contributors, and provides in one volume a concise yet comprehensive reference on all phases of pediatrics. It is readily adaptable to the needs of undergraduate medical students, pediatricians, and general practitioners. It is unusually readable, and highly technical subjects are simplified but with enough of the "why" to make the "how" understandable.

The book is up-to-date. It includes complete yet not exhaustive discussions of the child as an individual, from birth through adolescence, his growth and development, nutritional requirements in sickness and in health, the newborn, the premature infant, and the latest information on fluid and electrolyte balance, the indications, selection, and administration of fluids parenterally, the Rh factor, chemotherapy, blood dyscrasias, and allergy.

With regard to therapy the characteristic vagueness of former textbooks has been replaced by specific and detailed information, leaving little doubt as to therapeutic agent, dosage, and method of administration.

The book is well illustrated and includes several colored plates, and may be regarded as one of the best of the standard texts in the field of pediatrics.

R. W. B.

CLINICAL NOTE

Charlie couldn't drink. For about five years it had happened that the taking of even a single drink of liquor of any kind was invariably followed by rather severe sinus congestion, facial pain and headache. Codein was often necessary, but the symptoms had become so severe that liquor was completely excluded. Charlie's wife was unhappy; invitations had to be refused and a pick-me-up at home always met with such frowns that this, too, was impossible. Liquor in any form was simply out of the question.

In Dec. 1945, with a business trip in the offing and the almost-necessary social drinking to be done, the patient consulted me as to the possibility of a course of penicillin being of help in correcting his condition. Although I could see no reason to think that this would be of any avail, I had no objections to the trial, and accordingly prescribed a 25,000 unit tablet to be taken 4 times a day for the three days before the trip. This was done and the treatment was followed by complete success, which has thus far persisted for 3 months. Charlie is able to take a drink whenever the occasion arises, his wife is happy once more, and both agree that penicillin is indeed the "wonder drug."

My own conclusion, and my only one, is that those patients who ask if penicillin can accomplish anything are asking a very pertinent question.

ROBERT WILSON, JR., M.D.
Charleston, S. C.

LIONEL BARRYMORE HEADS NATIONAL ARTHRITIS FOUNDATION

Announcement was made today of the naming of Lionel Barrymore as Chairman of the National Board of Sponsors of the National Arthritis Research Foundation. The news was made public following a special meeting in New York of the Foundation's Officers.

The Foundation, to be located in Hot Springs National Park, Arkansas, is to serve as the national center for the study of the causes, treatment and prevention of arthritis and other rheumatic conditions. A campaign for \$2,500,000 for the construction and equipment of buildings and for scientific personnel was revealed following a conference between President Harry S. Truman and leaders of the Foundation last February.

Endorsed by medical leaders including Dr. Thomas Parran, Surgeon General of the United States Public Health Service, Major General George F. Lull, former Deputy Surgeon General of the Army Service Forces, Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, and other eminent scientists, the National Arthritis Research Foundation was started through the efforts of the officers and trustees of the Levi Memorial Hospital Association.

This institution, national and non-sectarian, has been devoted since 1914 to the free care of arthritic victims. Since its inception, it has ministered without charge to approximately 185,000 sufferers of rheumatic conditions.

In his telegram of acceptance of the chairmanship, Mr. Barrymore said:

"The crusade of the National Arthritis Research Foundation is a noble endeavor, and in its search for the possible causes and cures of this disabling disease merits the support of every American. For this reason, I accept the chairmanship of the National Board of Sponsors of the Foundation, fully confident that each of us will join in the endless effort to combat this enemy of mankind. It is my fervent hope that as a result of this enterprise the millions of men, women and children afflicted with arthritis may find ultimate relief. I do not hesitate to state that this is a great contribution to the American health standards, and upon mobilization of our individual resources our objectives will be attained."

Leaders in the National Arthritis Research Foundation include Louis Kranitz, St. Joseph, Missouri, Chairman of the National Campaign Committee; Hon. A. B. Frey, St. Louis, President of the Levi Memorial Hospital Association, and Henry Monsky, Omaha, President of B'nai B'rith, as Honorary Co-Chairmen; Walter W. Head of St. Louis, President of the General American Life Insurance Company, as Treasurer; Jack E. Flynn, Chicago, Loews Metro-Goldwyn-Mayer Pictures, as Chairman of the Amusements Division; Hon. Allen May, St. Louis, President of the Mutual Savings Life Insurance Company, as Chairman of the Insurance Division; and Sidney G. Kusworm, Dayton, as Chairman of B'nai B'rith Activities.

Mr. Barrymore, the noted Metro-Goldwyn-Mayer screen actor, has long been personally interested in scientific research in arthritis. In a further message to the Foundation, he declared:

"Too few people realize the sorry story of arthritis, and too many of those who have encountered the disease have been without hope of relief. The Foundation comes as the long-awaited answer to millions of sufferers."

The National Arthritis Research Foundation will embrace the entire field of rheumatic ailments including arthritis, rheumatic fever and kindred diseases. Hot Springs is one of America's best known spas. Its thermal waters, under government control, will be one of the subjects of research in the treatment of these diseases.

Arthritis is the most widespread chronic disease and is regarded as being first in medical, economic and social importance. Rheumatic conditions afflict about 7,000,000 Americans, one person in every 20, and totals more cases than cancer, tuberculosis, diabetes and heart disease combined. Arthritis is also the oldest disease of which science has definite record.

PROGRAM**Eleventh Annual Piedmont Post Graduate Clinical Assembly****September 17, 1946****AFTERNOON SESSION****Girls' High School Auditorium**

Greenville Street

Anderson, S. C.

- 2:30 Call to Order-----Dr. J. C. Scurry, President
Greenwood, S. C.
1. Cancer of the Tongue and Floor of the Mouth-----Dr. J. Elliott Scarborough
Winship Clinic, Emory Hospital, Atlanta, Ga.
2. Malignant Lesions of Bones-----Dr. O. L. Miller and Dr. Paul Kimmelstiel
Memorial Hospital, Charlotte, N. C.
3. Cancer of Colon and Rectum-----Dr. L. Carl Sanders
Baptist Hospital, Memphis, Tenn.
4. Present Status and Promise in Cancer Research-----Dr. George T. Pack
Memorial Hospital, New York, N. Y.

EVENING SESSION

John C. Calhoun Hotel

- Message from President of South Carolina Medical Association-----Dr. James McLeod
Florence, S. C.
- General Principles in the Surgical Treatment of Cancer-----Dr. George T. Pack
Memorial Hospital, New York, N. Y.

Officers of the Assembly

- Dr. J. C. Scurry, President-----Greenwood, S. C.
- Dr. Ned Camp, Secretary-----Anderson, S. C.

The Journal of the South Carolina Medical Association

SEPTEMBER, 1946

VOL. XLII, NO. 9

Article	Author	Page
Sympathetic Nerve Interruption in the Treatment of Organic Obstructive Vascular Disease	H. G. Smithy, M.D.	241
Pyelocystostomy in an Infant	Roger A. Way, M.D. George D. Johnson, M.D. Furman T. Wallace, M.D.	246
Some Technical Considerations in Thyroidectomy	Furman T. Wallace, M.D.	248

Editorials — The Ten Point Program — News Items — Book Reviews

BACKGROUND

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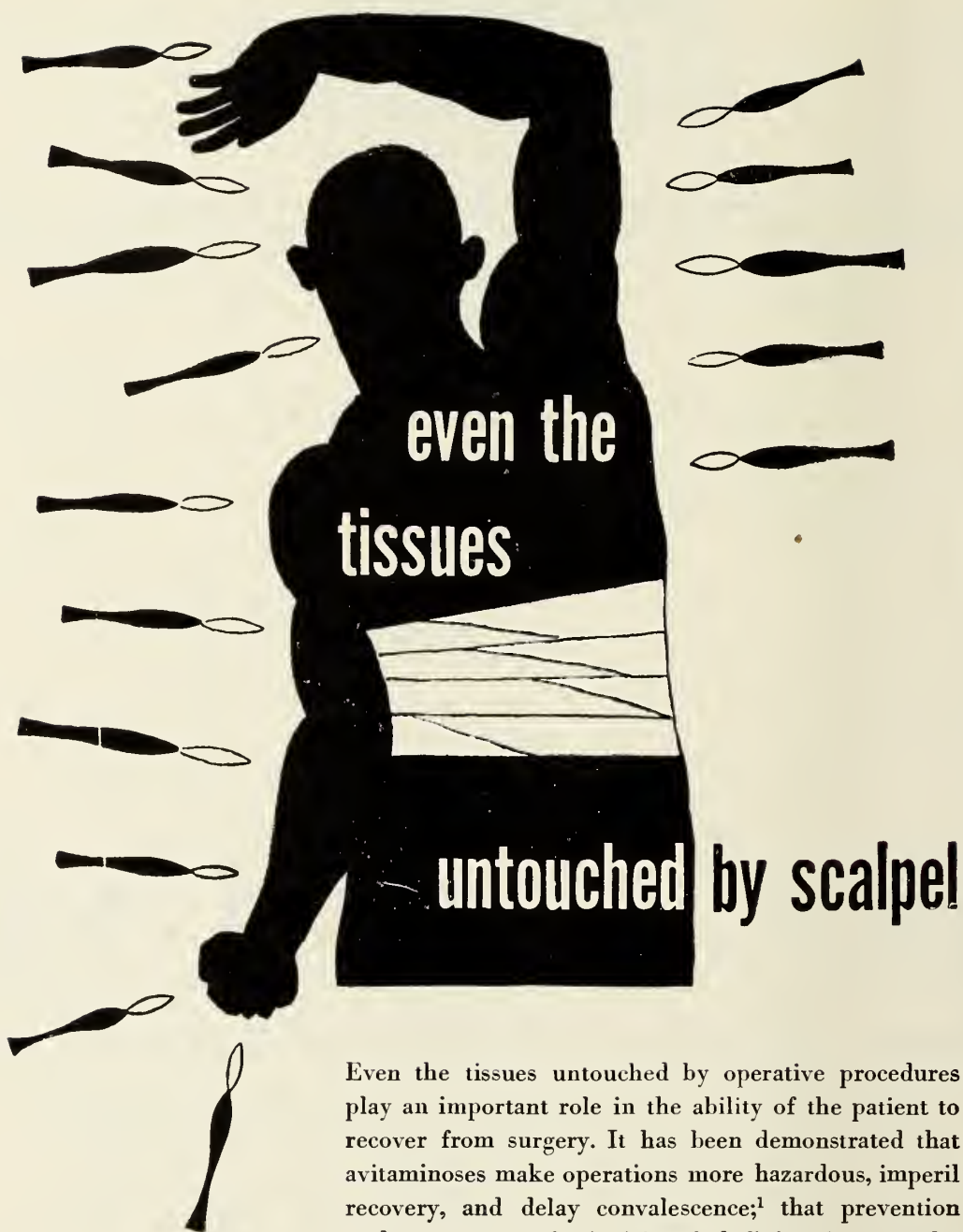
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1. Virginia M. Monthly, 72:240 (June) 1945.

2. Am. J. Surg. 54:299 (April) 1942.



FINE PHARMACEUTICALS SINCE 1886

U P J O H N V I T A M I N S

OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879 Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

September, 1946

NUMBER 9

Sympathetic Nerve Interruption in the Treatment of Organic Obstructive Vascular Disease

H. G. SMITHY, M.D.
Charleston, S. C.

During the past few years, over 100 patients have been subjected to some form of sympathetic nerve interruption on the Medical College service of Roper Hospital for 12 different surgical conditions.^{1,3} The production of vasodilatation by sympathectomy in peripheral vascular disease is not new. In its earlier application, this form of therapy was reserved for those conditions in which functional or vasospastic factors represented the underlying cause. Of more recent date, however, sympathetic nerve interruption has been utilized successfully in the treatment of organic arterial obstructive diseases.^{1,4,5} The ensuing discussion concerns its application to the management of 20 patients having one of the following occlusive vascular diseases: arteriosclerosis, Buerger's disease and peripheral arterial

embolism (Table I).

TABLE I

CONDITIONS FOR WHICH SYMPATHETIC NERVE INTERRUPTION WAS DONE

Disease	Number of Patients
Arteriosclerosis	
(a) Impending Gangrene	7
(b) Chronic Ulceration	3
(c) Intermittent Claudication	3
Buerger's Disease	4
Arterial Embolism	3
TOTAL	20

ARTERIOSCLEROSIS—Although a disease of progressive arterial obstruction, there are many patients having arteriosclerosis whose peripheral vascular bed contains numerous small vessels capable of vasodilatation. There are three specific instances resulting from arteriosclerotic ischemia which are amenable to sympathetic nerve interruption, namely, impending gangrene, chronic ulceration of the feet and intermittent claudication. In each, the beneficial effects obtained are due to increased oxygenation of the denervated extremities. This can be secured most effectively by surgical removal of the lumbar sympathetic ganglia. In poor operative risks, prolonged vasodilatation can be produced by paravertebral injection of alcohol into the lumbar ganglia.



FIG. 1—Arteriosclerotic dry gangrene with extension to dorsum of foot. Low amputation level obtained after sympathectomy and refrigeration.

From the Departments of Surgery of the Medical College of South Carolina and Roper Hospital.

(Read at Annual Session, S. C. Med. Assoc., Myrtle Beach, May 1, 1946.)

The painful rubor of impending gangrene can be abolished in some by lumbar sympathectomy, the operation restoring to normal the cold, reddish-purple foot. When frank gangrene has become established,

but demarcation has not occurred (Fig. 1), sympathetic interruption will delimit the process and permit amputation to be performed at a lower level. In addition to sympathetic interruption, cooling of the affected extremity by the application of ice is of established value in forestalling the development of gangrene and in preventing further spread of the undemarcated variety. Reduction of temperature of the ischemic tissues materially decreases cell metabolism⁶ and, consequently, the local oxygen requirement. Ischemic

indefinitely the function of ischemic limbs which otherwise would be seriously disabled. Sympathectomy is applicable from four standpoints: (1) to relieve rest pain occurring at night and the intense pain originating in ulcerations of the feet (Fig. 2), (2) to eliminate the discomfort of intermittent claudication, (3) to forestall the development of gangrene for a maximum period of time, and (4) to permit minor amputations at the lowest possible level in advanced cases wherein loss of the extremities has become necessary.



FIG. 2—Typical location of ischemic ulcers in Buerger's disease. Relief of rest pain originating in the ulcers after sympathectomy.

tissues can remain viable at low temperatures indefinitely⁷ while increased cellular metabolism induced by the application of heat hastens tissue death in the presence of impaired local circulation. It is probable that increased phagocytic activity following sympathetic nerve interruption⁸ is also an important factor in the prevention of gangrene. Thus, the combined effects of local refrigeration and sympathetic nerve interruption constitute a valuable method of minimizing tissue damage resulting from obstructive vascular ischemia; local application of heat is specifically contraindicated.

It must be recognized that arteriosclerosis is a chronic progressive disease and that sympathectomy is not designed to halt the process. In properly selected patients, the palliative effects of sympathetic nerve interruption are of great value in preserving the function of ischemic extremities for a maximum period of time and in forestalling the eventual onset of gangrene.

BUERGER'S DISEASE—The treatment of thrombo-angiitis obliterans by sympathectomy has been given an adequate trial and its value established.^{4,5,9,10} As in arteriosclerosis, the progressive nature of the disease is not influenced per se by sympathectomy but the operation provides a means of preserving

Operative interruption of sympathetic nerve impulses in thrombo-angiitis obliterans is applicable in either the early or late stages of the disease. In the former, there is usually a demonstrable element of vasospasm which is eliminated by sympathectomy thus decreasing the painful ischemia. In advanced cases, when the obstructive vascular process has become stationary and painful ulceration and gangrene are manifest, sympathectomy is of value in delimiting tissue damage and, in some instances, permitting the performance of minor instead of major amputations.

ARTERIAL EMBOLISM—Sudden embolic occlusion of a main arterial trunk is accompanied by a severe degree of vasoconstriction throughout the affected extremity. The resulting ischemia of the limb is profound and loss of viability follows promptly. The treatment of choice in early cases (preferably under 12 hours) is removal of the obstructing thrombus by embolectomy. A few hours after occurrence of the embolism, however, "tail" thrombi develop and are propagated distally into the arterial tree, thus producing disseminated vascular occlusion which is not amenable to operative removal. Interruption of sympathetic nerve impulses is of value^{11,14} in both the early and late varieties. As an adjunct to early embolectomy, it reduces the severe ischemia by eliminating arterial spasm. In the late cases, encountered after "tail" thrombi have developed, it offers the surest method of hastening development of a collateral circulation. If amputation becomes necessary, it can be performed usually at a lower level after sympathectomy while high amputations are virtually inevitable without denervation. As in other instances of impending gangrene, cooling of the denervated extremity is an important adjunct to sympathectomy in prolonging survival of the anemic tissues.

TABLE II

METHODS OF SYMPATHETIC NERVE INTERRUPTION AND RESULTS

Disease	Alcohol Block	Eucupin Block	Lumbar Sympathectomy	Satisfactory Results (%)
Arteriosclerosis				
(a) Impending Gangrene	2	0	5	71.4%
(b) Chronic Ulceration	0	0	3	100 %
(c) Intermittent Claudication	1	0	2	100 %
Buerger's Disease	0	1	3	100 %
Arterial Embolism	0	1	2	66.6%

RESULTS

Table II represents the methods by which sympathetic nerve interruption was produced and the results obtained in 20 patients having organic obstructive vascular disease.

In the arteriosclerosis group 13 patients were treated. There were two failures, both occurring in patients presenting evidence of impending gangrene. The first was subjected to lumbar sympathectomy, recovered satisfactorily and was discharged improved only to develop extensive gangrene of the foot two months later. The second case was one of severe diabetes mellitus whose general condition did not permit operation. Paravertebral lumbar ganglion block with alcohol was carried out and was followed by persistent elevation of skin temperature of the foot, indicating a satisfactory ganglionic infiltration. Gangrene developed rapidly, nevertheless, necessitating amputation. Excellent results were obtained in those patients having either intermittent claudication or chronic ulceration of the feet (Fig. 3). Of the

former, two are well one year after sympathectomy while the third has suffered recurrence of exertional pain in a mild form 14 months after alcohol injection of the lumbar sympathetic trunks. The indolent arteriosclerotic ulcers of the feet which were treated by ganglionectomy healed promptly, one being excised and skin grafted in conjunction with the sympathectomy. There has been no recurrence after 11 to 12 months.

Lumbar ganglionectomy was applied to 3 patients having thrombo-angiitis obliterans, while the fourth was treated by temporary interruption of sympathetic nerve impulses by paravertebral block with eucupin in oil. The latter, a long-lasting local anesthetic, is liberated slowly when injected in an oily vehicle and produces effects of considerable duration. Rather dramatic relief of the patient's excruciating rest pain and intermittent claudication followed eucupin block on three occasions. The remaining 3 patients complained of unrelenting burning pain in the feet and legs at night and each had much difficulty in walking due to intensification of the pain on exertion. Two of them had chronic indolent ulcers of the feet or toes (Fig. 2). Disappearance of pain and healing of the ulcerative lesions followed sympathectomy in each instance. Freedom from pain has persisted in the 3 patients for 5, 10 and 18 months respectively. Recurrence of ulceration was noted in one patient after 14 months. Neither major nor minor amputations have become necessary in any of the group.

Three patients having embolic arterial obstruction of the legs were treated by sympathetic nerve interruption. In one of these, the embolus had become arrested high in the left femoral artery, in another both popliteal arteries were involved, while the third showed evidence of low tibial obstruction. Embolectomy was not attempted in any of the group; the duration of the embolism was too great in the higher occlusions and the operation was regarded as impractical in the tibial occlusion. The latter case was treated by three paravertebral sympathetic blocks with eucupin in oil. After each block, performed at intervals of 3 or 4 days, there was marked increase in the skin temperature of the affected extremity indicating relief of the accompanying vasoconstriction. Disappearance of pain was prompt. Adequate collateral circulation developed and gangrene did not occur. The bilateral popliteal obstructions occurred in a 37-year old white man. He was first seen 6



FIG 3—The indolent painful ulceration of arteriosclerosis. Gradual healing and complete relief of pain after sympathectomy.

days after occurrence of the embolism at which time impending gangrene of the right foot was demonstrable. Both feet were cold and pulseless. Pain was intense. Bilateral lumbar sympathetic nerve block was produced by spinal anesthesia. Thermocouple recordings of the skin temperature of the feet before and after sympathetic block revealed an increase of 14 degrees (F) after the procedure, again indicating the severity of vasospasm in association with arterial embolism. The patient was subjected to bilateral lumbar sympathectomy; ice refrigeration of the right limb was employed for 24 days post-operatively. Frank gangrene finally developed in the refrigerated extremity. Because of the effects of the sympathectomy, closed amputation was successfully carried out through the calf at the junction of the upper and middle thirds. This site, of course, constitutes the ideal amputation level and the patient is now wearing a prosthesis and earning a livelihood 15 months after operation. The left leg and foot have remained viable and in good condition. The fact that one limb was saved and the other amputated at the ideal level in the presence of bilateral popliteal obstruction is convincing evidence of the value of sympathectomy in preserving viability of ischemic tissues. The patient having embolic obstruction of the common femoral artery was seen so late after the onset of the embolism that gangrene had become established to an advanced degree and sympathectomy was of little avail (Fig. 4).

SUMMARY

Interruption of sympathetic nerve impulses in the treatment of obstructive arterial disease is discussed. The various methods of producing sympathetic nerve interruption are mentioned and the results of treatment are presented in 20 patients having either arteriosclerosis, thrombo-angiitis obliterans or embolic arterial occlusion.

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FIG. 4—Extensive gangrene resulting from embolic occlusion of the femoral artery; severity of necrosis undoubtedly influenced by delay in operation and local application of heat in this case.

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DISCUSSION

Dr. George R. Wilkinson: Dr. Smithy has presented an excellent paper. In times past, we have had little in a mechanical way that could be done for those with vascular insufficiency in the extremities. The operative procedures proposed by Dr. Smithy, and illustrated so well in his slides, may seem somewhat radical, but actually they present a conservative approach. By this method of conservation, many extremities may be saved, and people kept in gainful occupations for a longer period of time.

We should not expect much to happen to the damaged vessels, but by taking away the spasm from the vessels smaller in caliber that have not been too severely damaged, new vessels can be developed, so that an extremity may regain its oxygen supply through improved detours, so to speak. The time honored method of applying heat to the extremities should be discouraged. It has been clearly shown by Blalock and others that increasing the temperature of the part adds to the amount of oxygen required, and instead of offering any relief, actually adds to the burden of an overly strained vascular bed.

Presentations of this sort point the way to a better day for people who come in to doctors and complain of pain, particularly in the lower extremities.

The Society is indebted to Dr. Smithy for this thoughtful study, so ably and simply presented. Perhaps our patients at home will be more willing to support the medical school when we carry such excellent ideas back home for the benefit of our patients.

Dr. John van de Erve: For your information I would like to say something about one part of this application of periarterial or lumbar sympathectomy which Dr. Smithy and Dr. Kredel have been doing in Charleston. It is such a common problem, I don't think we ought to skip it, that of chronic varicose eczema. I wouldn't be surprised if all of us have them. After proper treatment of varicose veins about 20% of those cases show hypostatic or varicose exema. This form of treatment is so startlingly productive that I feel it should be mentioned at this time. Some of these cases which I have seen have been treated by Doctors Smithy and Kredel by sympathectomy with excellent results. The results are so splendid that I would like to recommend that to you.

Dr. Douglas Jennings: I would like to ask Dr. Smithy the question—in speaking of sympathectomy in the lower extremities I assume he is speaking of lumbar sympathectomy. What is the advantage of lumbar sympathectomy over periarterial sympathectomy, particularly in the condition that Dr. van de Erve mentioned, in the dermatitis?

Dr. Kredel: Another part of the body is a site of vascular obstructive disease, namely the brain. For the past several years there has been a good deal of interest in the possibility of increasing circulation in the brain with sympathetic interruption. Most people have been using blocks by injection but more recently we have begun to use surgical interruption, in cases of cerebral thrombosis. The cases have been very few so far, but we are encouraged to go on with that work.

I would like to tell one story on Dr. Smithy and myself. You have heard how wonderful sympathectomy blocks are for acute thrombophlebitis. We had a fulminating Burger's disease. We did a sympathectomy, I did one side and Dr. Smithy did the other and on my side there immediately occurred a postoperative acute thrombophlebitis, in spite of no sympathetics.

Dr. Finger: I would like to call attention to the application of sympathetic nerve block in cases of post traumatic pain syndromes. We have had successful experiences with this form of treatment in the army where relief of pain, reduction of swelling and lowering of the amputation level (when the latter became necessary) resulted promptly after the block.

Dr. Epps: I would like to ask two questions.

I certainly enjoyed this very able article which deals with something that has been so hopeless from the surgical standpoint. I would like to ask Dr. Smithy what percentage of cases he found had syphilis as a cause of the obstructive vascular disease. I would like to ask him also if he feels this form of treatment would be advisable for a patient 75 years old, suffering with intermittent claudication and whose physical condition is fairly good? I might say this patient is in good financial condition and I want to keep her living as long as possible.

Dr. Smithy: I am very grateful to those who have offered this discussion. I appreciate all that had been said. That lady of yours, Dr. Epps, if she is 75 years old you better treat her conservatively, especially since she is such an important factor in keeping bread on your table. I would like to point this out: that patients too old for operation or who are poor surgical risks, there are many instances in which good results can be obtained by injection into the lumbar trunk or upper dorsal sympathetic trunk of 95% alcohol. That is not a procedure to be taken lightly but in certain selected instances alcohol block offers a good deal of benefit. I know of no cases in our series whose obstructive vascular disease was due to syphilis.

I would like to thank Dr. Finger for calling attention to the post traumatic pain syndromes of which many were seen during the past war. Excellent results are obtained in this group of diseases by sympathetic nerve interruption, especially when it is done early.

I would like to thank Dr. Kredel for his comments on obstructive vascular disease of the brain. This to me is one of the most important developments in this field of surgery, in recent years. He deserves great credit for having developed the technique of sympathetic denervation of the brain by stellate ganglion block, which he has been doing in Charleston for the last two or three years.

I am glad he pointed out that the patient developed the thrombophlebitis on the side upon which he operated and not mine!

Dr. Jennings asked the important question "What is the advantage of lumbar sympathectomy over periarterial sympathectomy?" Well, I think generally one can conclude this—that periarterial sympathectomy produces vasodilation of very short duration, it does not give a permanent effect and certainly not so long as lumbar sympathectomy. And one other point when one strips the femoral artery or any of the great vessels, immediately following there occurs a severe degree of constriction of the stripped vessel. There is no explanation for its occurrence, and it lasts for a period of several hours. In older patients who already have obstructive vascular disease, the resulting ischemia, even though of only a few hours duration, may precipitate gangrene.

Dr. van de Erve's remarks were self-explanatory.

It is a most important field. The results we have obtained in stasis dermatitis, treated by sympathectomy, have been excellent. I am grateful to him for calling attention to this important phase of sympathetic nerve surgery.

Pyelocystostomy in an Infant

ROGER A. WAY, M.D., GEORGE D. JOHNSON, M.D., AND FURMAN T. WALLACE, M.D.

Spartanburg, S. C.

From: Spartanburg General Hospital

The operation for anastomosis of the renal pelvis to the bladder, in order to bypass an obstructed ureter, was first reported by Hess in 1929.¹ The case, a 9-year-old male with hydronephrosis of the left segment of a horseshoe kidney, was again reported by Hess and Wright² in 1945. Although urological examination was refused, the patient had developed normally and was in apparent good health 16 years after surgery.³

A second case was reported by Hess and Wright² and by Wright alone.⁴ The patient was a 42-year-old male with a solitary ectopic kidney in which advanced hydronephrosis had resulted from a high insertion of the ureter with sharp angulation at the ureteropelvic junction. The patient had responded poorly to ureteral dilatation and had developed rapidly progressive uremia. Pyelocystostomosis was a life saving measure. The patient improved clinically, and radiographically there was marked diminution of the hydronephrosis.

The following is a report of an infant subjected to pyelocystostomy. Advanced hydronephrosis had resulted from intrinsic ureteropelvic obstruction in a solitary ectopic kidney.

CASE REPORT

W. L. F., a white male, age 4 months, was admitted to Spartanburg General Hospital on January 16, 1946 because he failed to gain weight, did not eat well, nor was he able to raise his head. A mass, which had gradually increased in size, had been noted in the right abdomen for some two months.

The patient weighed 9 lbs. 3 ozs. at birth. The delivery was normal and spontaneous. There was a previous admission at the age of 3 months for a respiratory infection. At that time a mass was noted below the liver.

Physical examination revealed a well developed but only moderately well nourished male infant. There was no nuchal rigidity or Kernig. However, the child seemed unable to raise its head from the bed and could not hold it steady when held in an upright position. No disorders of the ears, oral cavity, heart, or lungs were noted. The extremities and external genitalia were not unusual. The abdomen was soft and slightly distended. There was an ovoid, non-tender, semi-fluctuant, questionably movable mass in the right abdomen extending from below the liver

to approximately 1 inch below the anterior superior iliac spine. The liver extended 3 cm. below the costal margin. The spleen was not palpable. The right kidney could not be distinguished from the mass. No left kidney could be palpated although there was no difficulty in palpating the left renal fossa.

Laboratory studies showed a moderate degree of anemia, normal icterus index and blood bilirubin, and negative serology test for syphilis. Urinalysis showed a variable number of hyaline and granular casts, and occasional W. B. C. and R. B. C. Non-protein nitrogen ranged from 40 to 42 mgs.

Intravenous urography with 10 cc. of Diodrast was performed on two occasions without satisfactory visualization of the urinary tract although films were taken over a one hour period. A faint trace of Diodrast was seen in the mid right abdomen but no definite structures could be outlined. No Diodrast appeared on the left.

The temperature varied from 103° to 100°. Both penicillin and sulfathiazole therapy resulted in no appreciable effect. The child was not improving and continued febrile and somewhat toxic without demonstrable infection.

An exploratory laparotomy was done with a diagnosis of hydronephrosis of a solitary ectopic kidney. The peritoneal cavity was opened through a right rectus incision. The intraperitoneal content was normal except for incomplete rotation of the cecum. Transperitoneal palpation of the left renal fossa, and along the normal course of the left ureter showed no evidence of left kidney or ureter. Retroperitoneally there was a semi-fluctuant mass occupying most of the right side of the abdominal cavity.

The posterior peritoneum to the right of the ascending colon was incised and a hydronephrotic ectopic kidney found. The mass was composed chiefly of the dilated renal pelvis with a thin lateral rim of soft renal tissue composing about one-eighth of the mass. At the upper pole, the renal tissue was of relatively normal consistency. Moderate pressure on the renal pelvis did not induce emptying. The uretero-pelvic junction appeared externally normal. There was no congenital band or aberrant blood vessel. The first portion of the ureter was slightly tortuous, but the ureter, which was followed as far down as the pelvic brim, was otherwise normal.

Both the posterior and anterior peritoneal incisions

were closed. The peritoneum was stripped from the anterior surface of the bladder and from the right paravesical space. The right obliterated hypogastric vessels were ligated and severed. By further freeing of the peritoneum, the dilated renal pelvis was exposed retroperitoneally. When the closed peritoneum and its content were retracted medially, the lower pole of the mass was in apposition to the dome of the bladder.

An anastomosis was fashioned between the bladder and the kidney pelvis. The inferior aspect of the pelvis was sutured without tension to the right superior aspect of the bladder with a continuous 00 chromic catgut suture on an atraumatic needle. Transverse incisions approximately 2 cm. in length were made in the bladder and renal pelvis and a stoma was formed by approximating the edges of the incisions with a continuous suture of 00 chromic catgut. The posterior suture was continued anteriorly forming a double layer closure. Penrose drains were placed on the anterior and posterior surface of the anastomosis and brought out through a stab wound to the right of the original incision. The abdomen was then closed in layers.

Postoperatively the temperature went to 105° but gradually returned to normal to 100° on the 3rd postoperative day and remained at this level throughout hospitalization. There was no urinary leakage at the site of anastomosis. The incision healed by first intention. The skin sutures were removed on the 5th day, the drains were shortened gradually after the 4th day and were removed on the 10th.

After operation the child's appetite improved, and he seemed brighter and less toxic. There was gross blood in the urine for the first 48 hours and microscopic blood for 5 days after operation. The act of voiding seemed to cause the patient pain a week after operation for a period of several days but otherwise there was no urinary difficulty or frequency and the abdominal mass was no longer evident.

Six weeks after operation the non-protein nitrogen had been reduced to 22.5 mgs.

Three months after operation he weighed 17 lbs., ate and slept well. He could hold up his head and was apparently normal for the first time.

DISCUSSION

Pyelocystostomy was selected instead of ureteropyeloplasty since the procedure shortened the operating time in a poor risk and avoided a nephrostomy and ureteral splinting with certain resultant infection of the kidney. Urteropelvic surgery, no matter the operation selected, cannot assure a functional result in all cases. Some 15% are failures. Since the patient had only one kidney which was markedly hydronephrotic the procedure followed seemed safer. Unlike the two previously reported cases, post-operative catheter drainage was not employed. Troublesome urinary tract infection with subsequent damage to renal function, as in one recorded case, did not develop.

SUMMARY

An infant with a solitary ectopic kidney with hydronephrosis the result of intrinsic ureteropelvic obstruction is presented. Anastomosis of the renal pelvis to the bladder resulted in disappearance of the tumor mass, lowering of non-protein nitrogen, and improvement in the general condition of the patient. Diversion of urine, by catheter, was not employed and post-operative urinary tract infection avoided.

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Some Technical Considerations in Thyroidectomy

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The local factors which influence wound healing and the degree of post-operative reaction after thyroidectomy will be discussed.

The first of these factors is the selection of anesthesia. The advantages of a general anesthesia are that the operative time is shortened, and there is less psychic trauma to the patient. Also an intra-tracheal tube can be used if desired. On the other hand, local anesthesia may be used. Its first advantage is that the status of the recurrent laryngeal nerve can be determined by having the patient cough or talk. The most important advantage, however, of local anesthesia is that it limits the amount of operative trauma that the surgeon produces. Thus under local anesthesia, the surgeon is prohibited from exerting undue traction on the neck structures because of the discomfort to the patient that results. Every action must be done gently and carefully. The result is that the trachea is not compressed during delivery of the lobe and the tissues are not subjected to the injury that can be produced by strong traction. An example of the amount of pressure that can be exerted under general anesthesia is that some who use intra-tracheal anesthesia require a steel reinforced intra-tracheal tube because the rubber tube is compressed during the more difficult parts of the delivery. The gentle handling of the tissue is reflected in the degree of post-operative reaction of the patient. There is less edema, less discomfort, certain complications are fewer in number, and a shorter period of hospitalization is required. While it is true that the surgeon may develop his technique to the point where he will not exert undue traction under general anesthesia, it is felt that most surgeons require some limiting factor.

As far as the actual incision is concerned, the placement of the incision is worthy of mention. It is usually made transversely about half way between the sternal notch and the prominence of the laryngeal cartilage. It should be kept in mind that in particularly large goiters, after the goiter is removed, the incision will be much lower as a final result than it was placed at the time of operation. If the incision is not made high in these cases, the resulting incision will be down overlying the clavicles and sternum and will produce an ugly scar.

In the case which requires division of the pre-

tracheal muscles to obtain the necessary exposure in an unusually large goiter or an intra-tracheal goiter, the division of these muscles should be accomplished at a much higher level than the skin incision. If the pre-tracheal muscles are divided at the same level as the skin incision, the scar will extend in depth to the trachea and an annoying tracheal tug will develop due to scar tissue adherence.

Only the smallest sizes of suture material should be used during the thyroidectomy. Non-absorbable suture, such as cotton or silk, produces less foreign body reaction and consequently less edema and inflammatory reaction.

There are two major techniques of performing thyroidectomy. The first is to secure the upper and lower pole after identification of the recurrent laryngeal nerve, and to deliver and remove the lobe after placement of only a few hemostats. This technique has given good results in the hands of those accustomed to it. The second technique differs mainly by the method of securing hemostasis. After the isthmus has been divided and the pyramidal lobe removed, the smaller branches of the vessels are secured on the surface of the gland, and in each instance are clamped before they are divided. It is necessary to use a great many hemostats in this technique, but there is usually no bleeding during the procedure. The field consequently is always dry and the postero-medial portion of the capsule is easily preserved, thus protecting the recurrent laryngeal nerve and the parathyroids. Also, any extension behind the trachea or at the superior or inferior pole can be definitely removed as the procedure of clamping and dividing is continued in each direction. As a general rule, no vessels have to be secured while they are free and possibly retracted. Thus the danger of inadvertently clamping the recurrent nerve is minimized.

The last factor which is to be discussed is the question of drainage of the incision. If the above principles of gentle handling of tissue, absolute hemostasis, small bites in each clamp, and the use of fine suture material with an absolute minimum of suture material left in are carried out, no drainage of the incision is required. A drain will not serve as a substitute for good hemostasis. It gives a false sense of security in that it will not decompress a severe post-operative hemorrhage. The essential treatment of a post-operative hemorrhage and its

resulting respiratory obstruction is to open the incision and allow the blood to escape. This immediately relieves the respiratory obstruction, which is the dangerous factor.

As far as the post-operative care of the incision is concerned, it is felt that a light pressure dressing using a rubber sponge or elastic bandage is conducive to good wound healing. The skin clips are loosened on the first post-operative day and removed on the second, and usually the patient is up and discharged on the third day.

The above technique has been used in large numbers of thyroidectomies by various surgeons. We have previously reported the use of this technique in intrathoracic goiter¹ and discussed at that time problems peculiar to intrathoracic goiter. One important principle discussed was the use of morcellation as emphasized by Lahey.² By this procedure, the capsule of the intra-thoracic goiter is entered and the interior of the mass broken up and removed to decrease the transverse diameter and permit delivery through the thoracic strait. It should be noted that the surgical trauma is confined to the interior of the mass which is subsequently removed. Another important principle discussed was the proper maintenance of an airway as advocated by Prioleau.³ It was mentioned that drainage of the mediastinum was not required in all cases.¹ An additional case has been done since then, the report of which follows:

CASE REPORT

Spartanburg General Hospital No. 21180

A 43-year-old colored female was admitted to Spartanburg General Hospital on August 6, 1945. The past history revealed that the patient had a previous thyroidectomy in 1932, and a large recurrence on the left side of the neck was removed in 1941.

When seen in August, 1945, the patient had a large intra-thoracic goiter with no mass palpable in the neck. A marked stridor was present, the patient using considerable exertion to obtain the necessary respiratory exchange.

Operation was performed under local anesthesia. After identifying the upper portion of the mass under the left clavicle, it was removed using the principles discussed above. The mass extended well below the arch of the aorta. No drainage of the resulting cavity was required, and the patient went home on the fourth post-operative day. The patient was followed in the out-patient clinic until September 28, 1945, and had no difficulty.

DISCUSSION: When thyroidectomy was first performed in cases prepared by thyroauricil, considerable difficulty was encountered because of the increased vascularity and friability of the gland. In some cases, the operation had to be discontinued because

of bleeding, the incision packed, and thyroidectomy completed at a later date. However, with the addition of iodine to the pre-operative regime in the last week preoperatively, the acini become distended with colloid and vascularity is much diminished and the consistency of the tissue is returned more nearly to that usually seen in an iodine induced remission. Thyroidectomy in these later cases has been accomplished without undue difficulty.

SUMMARY: Some of the local factors which influence the healing of the thyroidectomy incision, and the degree of post-operative reaction have been discussed.

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DISCUSSION

By DR. WILLIAM H. PRIOLEAU

Thyroidectomy is a highly technical procedure due to the vascularity of the gland, the immediate proximity of the recurrent laryngeal nerves, and not infrequently the presence of distortion and compression of the trachea. Dr. Wallace has ably called our attention to certain technical considerations which are conducive to the best results. Local anesthesia adds to the safety of the operation by not depriving the patient of the normal protective reflexes of coughing, swallowing, and talking. Its use insures a gentle technic. The kind of suture material has a most important bearing upon the healing of the wound, after giving more than adequate trial to plain catgut, chromic catgut, silk, and cotton, we now use #60 cotton exclusively. It gives the safest ligatures and is best tolerated by the tissues, even in the presence of infection. A firm dressing with sponge rubber splints the wound and promotes nice healing.

Our use of thionuracil is limited to those few very active cases which cannot be prepared satisfactorily for operation by iodine therapy. Even in these cases we discontinue the thionuracil some two or three weeks before operation, and during this period give iodine. Thionuracil therapy is accompanied by considerable risk of inducing agranulocytosis and other untoward effects. There is little evidence that it produces a permanent cure.

The Journal of the South Carolina Medical Association

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Office of Publication: (In care of the Editor) Florence, S. C.
Subscription Price \$3.00 per Year

SEPTEMBER, 1946

THE Rh FACTOR

Of the many recent developments in medicine probably none has given rise to more confusion than the bugbear known as the Rh factor, a knowledge of which is important to every physician doing either obstetrics or pediatrics. In an attempt to clarify this situation, at least in part, we offer herewith a few of the essential facts concerning it.

The Rh factor is an antigen, the nature of which was first observed in the erythrocytes of rhesus monkeys, whence the term "Rh" is derived, and which has subsequently been found to be present in the red blood cells of 85% of the human population. The blood of individuals possessing this antigen is designated Rh positive (Rh+) and those persons who lack it are termed Rh negative (Rh-).

Its importance lies in the ability of this antigen to stimulate in the serum of Rh- persons the production of hemolytic antibodies. Untoward results in which the Rh factor is involved are (1) Erythroblastosis fetalis or hemolytic disease of the newborn and (2) hemolytic reactions to repeated transfusions of whole blood from otherwise compatible donors.

It has been found that such conditions can, in large measure, be prevented by Rh typing during pregnancy, with appropriate treatment as indicated, and Rh typing before transfusing female patients.

Erythroblastosis fetalis may occur when the mother is Rh- and the father and fetus are Rh+. The Rh antigen in the fetus passes through the placenta, and thus reaching the maternal circulation stimulates in the serum of the mother the production of antibodies (agglutinins) which, returning to the fetal circulation by the same route, cause agglutination and hemolysis of the red blood cells of the fetus before or shortly after birth. The process sensitizes the Rh- mother to Rh+ blood, and with each successive pregnancy this sensitization is increased.

An Rh- woman who has become sensitized to Rh- blood, either by an Rh+ fetus or from having been the recipient of a blood transfusion from an Rh+ donor at any time in her life, becomes a hazard

to any subsequent transfusion. By the same token the serum of an Rh- woman sensitized through Rh+ transfusion even as far back as childhood may have a deleterious effect upon her first baby. The possibility of an erythroblastotic fetus then increases with each subsequent pregnancy of the Rh- mother.

The treatment of erythroblastosis fetalis lies primarily in transfusions of group compatible Rh- whole blood. If an Rh- donor is not available then a suspension of washed maternal red blood cells may be used, provided of course that mother and baby are group compatible. Large doses of Vitamin K are also indicated.

The prevention of such occurrences is of even greater importance than the treatment, and consists of two major considerations: (1) Routine Rh typing of recipient before transfusing any female of any age, in addition to the regular A & B grouping and cross matching. If the recipient is Rh- then it is imperative that an Rh- donor be sought. (2) The adoption of routine Rh typing early in every obstetrical case. If the patient is Rh- and her husband is Rh+ then precautions may be taken against the loss of what may be an erythroblastotic fetus. Signs of fetal distress may be an indication for interruption of pregnancy, and a pre-selected Rh- donor for the baby may be the one means of saving its life.

In light of present knowledge, the physician who transfuses whole blood into female recipients, or who cares for a patient throughout her pregnancy, without first determining the Rh factor is assuming the responsibility for what may lead to serious or even fatal consequences.

R. W. B.

ANDERSON COUNTY MEMORIAL HOSPITAL

Recently there came to our desk a well illustrated pamphlet, bearing the heading "A Great Memorial." It tells the story of the Anderson County Hospital and of the plans for greatly enlarging and supplementing the present physical plant. In clear and

succinct form it tells of the needs and the hopes for this institution.

We wish to commend those who are responsible for this splendid little brochure. In pictures and in words it presents its message with clarity and force. And we join with others throughout the state in wishing them every success in this great venture.

HOUSE OF DELEGATES MEETING AMERICAN MEDICAL ASSOCIATION

San Francisco, July 1-5, 1946

The recent meeting of the American Medical Association in San Francisco was of unusual interest to me as it was my first visit to this City and State. California needs no boost for its scenic grandeur, but I would be amiss not to express appreciation for the warm and considerate hospitality of the San Francisco Medical Society. The meeting was splendidly housed, conveniently arranged, and in spite of a street car strike during our visit every effort to meet our transportation needs was made. There was a large attendance, primarily of course from the more Western States, but with many members from all States.

The House of Delegates has been a serious and busy organization. It is making every effort to do a good job. The last few years have seen determined efforts by a not too small group of social and bureaucratic minded reformers of varied shades to bring about in this Country compulsory health care plans such as have been promulgated in several other Countries, notably England, Germany, New Zealand and others. Certainly not all criticism has been unjust. There is a need for careful economic planning to the end that the medical profession might continue, without political pressure groups and bureaucratic interference, its real purpose and desire, which is to serve the people of this Country to the best of our ability. Perhaps we have been so interested in the scientific accomplishments of our profession that we are a bit belatedly tackling this problem. Certainly much of the criticism of recent years has been political bunk. There is no group of citizens more interested individually or collectively in national health and social security than the physicians. Their record of service and availability speaks for itself. The medical records of this recent World War have been the subject of much praise from many sources. I would like to remind those who think the old way of education and of training doctors is wrong, that this work was done by the medical officers who had such training. The younger medical officers who had completed their accelerated program of education and their abortive internships were willing indeed, but they simply could not have done the job. They must return to civil life and civilian hospitals for further training

to become the type of doctors the public expects and demands.

The House of Delegates met at the St. Francis Hotel on July 1, 2 and 4. These meetings were regularly attended by all members. Some Reference Committees worked on their jobs on the 3rd as well. There was great interest in the various political activities now going on in Washington and in some State Capitols. There is real concern for the future of American Medicine as we know it. The Officers and Trustees and Delegates are serious in their approach to the problem.

After the addresses of President Roger Lee and President-elect Harrison Shoulders, the Speaker of the House appointed the various Reference Committees. Many resolutions were presented and properly referred for hearings and recommendations. I was appointed to the Reference Committee on Legislation and Public Relations and found myself a busy person indeed. This Committee was in session most of the first four days so that there was little opportunity to attend the scientific sessions. Dr. Edwin S. Hamilton of Illinois was chairman of my committee and proved an experienced and able one. The reports of the activities of the House have now been published and are available in the Journal of the American Medical Association of July 13, 20 and 27. These reports are important and are good reading for all doctors interested in medical practice.

To mention a few features here is all I can hope to do. The Annual Distinguished Service Award was bestowed on Dr. J. A. Carlson of Chicago. He is a distinguished Teacher and Physiologist who has made many contributions to medicine. It was a happy choice and honors a man who richly deserves it.

Dr. Olin West, until this year secretary of the American Medical Association, was unanimously elected President-elect. Dr. West has served the Association for many years and has won the esteem and affection of many members by his unfailing courtesy and considerate helpfulness. Another fine honor to Dr. West was the presentation to him of a silver service by the San Francisco County Medical Society and the House of Delegates.

Dr. Edward L. Bortz of Philadelphia, a member of the medical faculty of the University of Pennsylvania, was elected Vice-President. He is an active and able physician and well fitted for this position.

Dr. Roger Lee always speaks with eloquence and thought. Discussing the Hill-Burton Bill which has been approved in principle he said "If the execution of the Hill-Burton Bill depends not on need but on political pressure, then the medical profession has exchanged a part of its birthright for a Mess of Pottage." He expressed the opinion that individually and collectively the medical profession should participate more actively in public affairs, both for its own

and the public's good. Also that the younger members of the profession are more vitally interested in the changing order of medical practice. These are the ones who bear most of the responsibility of working out many of the details of prepayment medical care plans and other evolutionary changes now on the horizon. These younger men should become increasingly active in medical societies and a larger share of the work of these societies should be expected of them.

Dr. Shoulders' address was forceful and promises an active year under his Presidency. The addresses of these two men are in the Journal of the American Medical Association of July 13 and are recommended reading.

The By-Laws are now changed so that the House of Delegates will meet semi-annually. So much political activity in Washington seems to demand this. Probably one meeting will be held in Chicago in December and the other as before at the annual meeting of the American Medical Association.

The Veterans Care program approved by our State Association at Myrtle Beach this year is in general much like other State approved plans. The remaining States which have not arranged such a plan were encouraged to do so as soon as possible.

A change in the By-Laws made this year states that "Fellows shall receive the Journal of the American Medical Association." Briefly this means that

from now on Fellowship dues will include the subscription cost of the Journal.

The report of the Board of Trustees was important. Last year a firm of experts on public relations was employed to study and report on methods and means of improving our national organization and improving our publicity. Their report was not available in full to the House because it was received too late for digest by the Board. No doubt this report will stimulate changes in the organization, which may have become a bit self satisfied, and much good might result. One recommendation made was a definite separation of the functions of scientific interpretation and medical economics and the direction of public relations. Such plans are now formulating. Dr. Fishbein will be editor of the Journal and of Hygeia. A well qualified man will be found to work with Dr. George Lull on public relations.

The scientific exhibits were up to their usual standard of excellence. One can spend many hours with them.

One of the most delightful events socially was a banquet given to the House of Delegates by the San Francisco County Society. It was a lovely and lively party and proved beyond doubt that those fellows out there are truly delightful hosts.

To my State Association I say thank you for the privilege of representing you as your official delegate.
Hugh Smith, M.D.

The Ten Point Program

• M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

THE END OF S.1606

With the adjournment of Congress, the proposed National Health Act of 1945 (S.1606), died in the Committee on Education and Labor, before the lengthy hearings on the bill had been completed. For several months predictions from the best informed sources had been to the effect that the bill would never be reported out of committee. But the fact that these predictions proved accurate was no fault of the proponents of the bill, and not for any lack of strenuous effort on the part of its friends, within and without the Congress.

The hearings by the Committee, under the leadership of its Chairman, Senator Murray, from all accounts, were anything but a cool and dispassionate attempt to obtain the facts on both sides of the controversy. Introduced by a hot exchange between the Chairman and Senator Taft at the very opening, the hearings were continued in an atmosphere which was not calculated to bring about any satisfactory

result in the form of constructive legislation. The sessions are referred to in the editorial department of one medical Journal as "the longest, most searching inquisition to which American medicine has ever been subjected." The fact that despite this attitude and the efforts of the proponents of the bill, it never saw the light of day after being committed to Senator Murray's group, should be considerable gratification to the doctors.

We have no fear of anything that may be revealed by the most careful and searching scrutiny of the history of the medical profession or attempts to attribute to it ulterior motives even though such inquiries and investigations be conducted in an "inquisitorial" manner. The fact that despite the determined effort introduced and launched by a special message from the President to the Congress last November, after a long period of efforts to "soften up" the opposition to the bill through a constant barrage of verbal missiles, failed to accomplish the desired results against the better judgment of our

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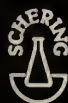
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representatives in Congress who sensed the will of their constituents at home, is encouraging and tends to renew our faith in the soundness of the democratic ideal and the capacity of the will of the majority to prevail against the attempts of a determined minority.

But the end of S.1606 does not mean the end of Messrs. Wagner, Murray and Dingell, or of the efforts by those who share their views. There is no sound reason to believe that past events will discourage them materially, and a renewed effort through the introduction of other bills may be confidently expected soon after the new Congress convenes.

The public is far better informed about the real implications of the measure now than before. The secret of ultimate defeat of such legislation and the turning back of the efforts of those who would bring to this nation complete socialism or something worse, lies in fully informing the people of the United States as to what it would mean. The efforts of the medical profession so far have been generally in the right direction. They can only succeed finally if the positive approach is maintained through the continued determination to devise a reasonable substitute for the Utopian schemes offered by the social planners who would rely on government for everything.

POLITICS AND MEDICINE

Apropos of developments in South Carolina within the past few weeks are the remarks contained in an editorial in the March issue of the Connecticut State Medical Journal:

"Medicine must recognize the fact that, whether it likes it or not, social reform along a wide front will not be accomplished without action on the part of our politicians. Without effort on our part it is futile for us to expect to be enacted only that legislation of which we approve and it is also futile for us to approach the political scene unless we come equipped with understanding and a spirit of cooperation.

"The professional contribution of the physician to community life is indeed important but too often for his own good he has become detached from the political life of his community. In commenting upon the political decadence of one American city, Lord Bryce once declared that, 'the most dangerous enemies of reform have not been in the ignorant and poor, but men of wealth, of high social position, and character.' Someone has recently said that intelligent people who refuse to share in the political life of the community may be considered 'civic conscientious objectors'."

It is high time that professional people realize that after all, Democratic government is based upon

and directly controlled and dominated by "politics." If it were not, it would not be democracy. If government is actually by the people, then the influence of the people will and should be brought to bear upon those in office and those seeking office, and the inter-play of such influences and the response of officeholders and office-seekers to those influences, make up what we generally term "politics."

A politician, we assume, is one more or less skilled and engaged in the practice of politics. Of course, there are varying grades of politicians, as there are lawyers, ministers and even doctors. It is extremely pleasing to numerous people in other walks of life to find that in South Carolina the medical profession does not consider itself above participation in politics, that its members are concerned with proper government and public service. It is highly gratifying that a distinguished member of the medical profession has had the temerity to enter aggressively and wholeheartedly into a statewide political race, and that his personality has been such as to accomplish the results achieved in the recent primary elections.

THE PRESIDENT AND THE WAGNER-MURRAY-DINGELL BILL

The Observer of events and developments for the Medical Society of the District of Columbia who conducts an excellent department in its Medical Annals, raises an intriguing question in the April '46 issue, to wit: "Does President Truman approve" of the Wagner-Murray-Dingell Bill?

Recalling the President's message of November 19, 1945, to Congress calling for the enactment of health legislation incorporating compulsory insurance, and the fact that the 3rd of the bills was introduced on the following day, he acknowledges the logic of the conclusion which was immediately drawn that the bill was endorsed by the President.

The Observer continues that to his knowledge not a word has been uttered by the President to indicate his attitude one way or the other in respect to this particular bill. As a matter of fact, he continues, "It is known that he (the President) is studying the whole matter and has not yet made up his mind as to the exact type of legislation he will approve. He is deeply interested in medical care and believes something must be done to improve its distribution. As stated previously in this column, he has little confidence in leaders of organized medicine. This is unfortunate and, in your Observer's opinion, not readily remedied. But it is not an insurmountable obstacle although there is little possibility that this administration will become friendly to organized medicine unless there is a change in its leadership.

"It is your Observer's guess, and it is only a guess, that if the President does approve a health bill incorporating the features described in his health message, *it will not be the Wagner-Murray-Dingell Bill.*" (Italics added.)



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In view of the location of the Observer at the very heart of the national scene, his considerable experience with medical affairs and, we judge, to some extent with political developments in the nation's capital, we were particularly interested at the time with the foregoing observation by him and especially with the final words which we have taken the liberty to emphasize.

So far as the particular bill under consideration at the time they were written is concerned, the Observer's prediction has proved correct. Actually, however, the President did not have an opportunity to approve or disapprove that particular bill for enactment into law. The interesting question now is whether the President will give his blessing, and finally approve if presented to him by the Congress, a future measure by the same authors or someone else, embracing the objectionable features of S.1606.

WHY HAVE A CONFERENCE OF PRESIDENTS?

JULIAN P. PRICE, M.D.
Florence, S. C.

(We are publishing this article over the protest of the Editor of the Journal. It has already been quoted in other state journals and in view of its bearing upon the work of this department, we feel justified in insisting upon his granting permission for its use.)

When I received the invitation to appear on this program, I felt sure that some member of the Executive Committee had a keen sense of humor. Why else would you find an ordinary secretary of a small state medical association appearing on the same platform with such eminent speakers as Dr. Anderson, Dr. Goin, Dr. McCormick, and Mr. Close. Secretaries, as I have oft been told, are supposed to be seen and not heard—and it is a real novelty for one to be afforded the opportunity of expressing his thoughts before such a distinguished group. On behalf of state association secretaries, therefore, I wish to thank you for the recognition which you have given us by this gesture. I but hope that my colleagues will not be too ashamed of their representative today.

After two preliminary gatherings, this Conference of Presidents became a national organization at a meeting in Chicago last December. At that time, by-laws were adopted, officers were elected, and plans were made for an annual convention.

Read before the Conference of Presidents and other officers of the State Medical Societies held at the Sir Francis Drake Hotel, San Francisco, California, on Sunday, June 13, 1946.

Along with many of those in this audience it was my good fortune to be invited to attend that organizational meeting and to become a charter member of this Conference. I deemed it a Privilege to be associated with such a group, and yet I could not refrain from asking myself the question, "Why Have a Conference of Presidents?" Surfeited as we are by attendance upon meetings, beset as we are by invitations to attend this and that conference, what excuse could there possibly be for another organization? Could a conference of this type serve any useful purpose or would it eventually become a pleasant social gathering where kindred spirits would meet and while away a few hours together? Would the effort expended in the promotion of such a conference be worth the results obtained? These questions suggested themselves to me and I have no doubt that they also came to some of you.

As I have attempted to answer these questions in the light of the meeting which was held last year and in the light of my experience with various other medical bodies, I have come to this definite conclusion—The Conference of Presidents is not only worthwhile but it can become one of the greatest forces in the progress of medicine in this country of ours.

Although this Conference is composed of the elected officers of the various state medical associations, it is an independent organization accountable only to itself for what it does. Herein lies its strength and also its responsibility. Free from the shackles of tradition, unfettered by the limitations of precedent, this Conference has an unrivalled opportunity to bring to our profession aggressive and progressive leadership.

As I understand it, the founders of this organization intended that this should be a deliberative body, using the power of suggestion and stimulation rather than the power of action as its source of strength. With this idea I am in full accord.

There are in existence today a sufficiency of medical associations on a local, state, and national level to do the work which ought to be done. But there is a crying need for some organization which will serve us in the dual role of the dissecting knife and the catalytic agent—the dissecting knife to show in clear relief the points of strength and the points of weakness in our various medical bodies, the catalytic agent to stimulate into dynamic action those forces which now lie dormant. It is my sincere belief that this Conference has been and will continue to be such an organization.

Having established the why and wherefore of our existence, the next step is to consider the courses of action which we might pursue, and I shall now present for your consideration certain specific activities which this Conference might undertake. I realize that there are many in this audience who

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*N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154

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are more capable of making such suggestions than I am and it is my hope that during this or subsequent sessions of this Conference opportunity will be afforded for a presentation of these ideas.

My first suggestion is that this Conference attempt to awaken the sleeping giant of our medical organizations—the county medical society.

The county medical society is not only the unit upon which our state and national organizations are built, but it is also our greatest source of strength—a fact which many of our state and national leaders do not appreciate or else ignore. Ask the man who is seeking political office where he looks for his support. He will tell you that district and state organizations are of great value but that what actually counts is what happens down in each individual ward. We are not politicians—not yet, at least—but we can certainly learn a lesson from those who are.

Come with me to a get-together of an average county medical society. First, there is a brief period of greeting and hand-shaking. In some instances this will be followed by a Dutch supper. Then comes the scientific program—several papers, some good, some not so good. A short business session follows with one or two committee reports. Finally, the motion is made to adjourn and the members go home.

To the physician who is only interested in the scientific phase of medicine, such a meeting may be a success. But no physician is merely a scientist—he is a citizen, a tax-payer, a member of society, and as such he has obligations and responsibilities which he cannot ignore. He is living in a time of social change, a change which will involve all phases of social life, including the practice of medicine. He, as a physician, is the one who should be leading and directing the changes which are taking place in the field of medicine. But how can he, if he and his colleagues bury their heads in the sand of scientific medicine to the utter disregard of what is going on in the world about them.

The county medical society is the only group through which we can awaken the physicians of America to the need for concerted thought and effort. It is the only group which reaches these physicians in person. Such being the case, we must stimulate each county society to have as a definite part of its regular meetings a period allotted to a discussion of medical care in its broadest sense. Local problems—and what county is there in this land of ours which does not have a local medical problem—state problems, national problems, all of these should be matters for consideration. And these matters should be considered and discussed not by special committees but by the entire membership where everyone present will have a chance to present his views. From these discussions, plans of action will evolve and programs will be formulated—programs which will

give to the people of this country the type of medical care which they need and which they deserve.

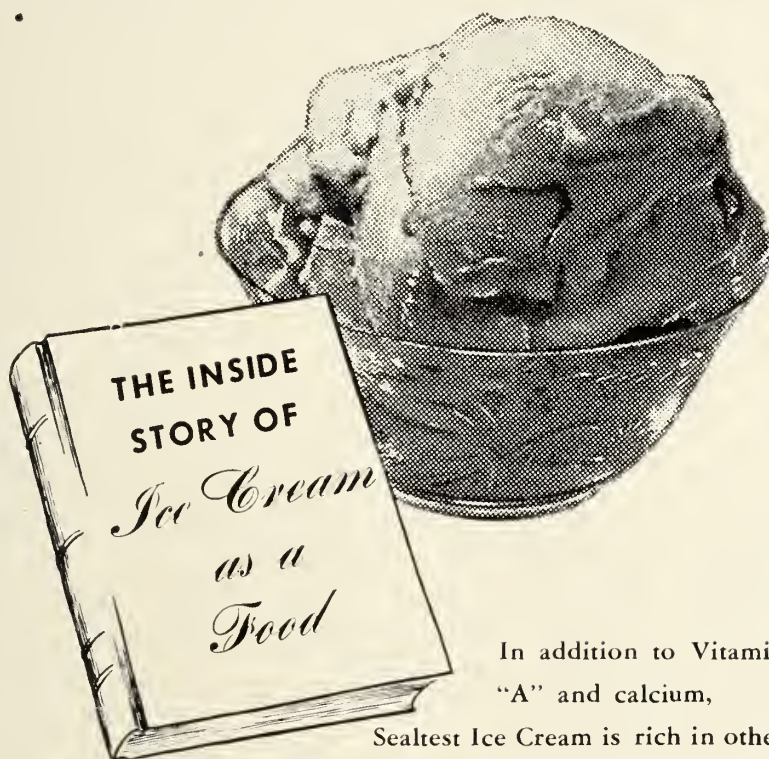
Perhaps you are saying—this sounds all right, but what has it to do with this Conference of Presidents. Sitting in this audience are officers of state medical societies who will, during the coming months, visit many if not most of the county medical societies in this country. What greater contribution could these men make to our profession than to awaken this sleeping giant—the county medical society—and to stir him into action.

A second activity to which this Conference might direct its attention is that of stimulating our state associations toward adopting more comprehensive programs in the field of medical care, based upon conditions and needs as seen by physicians and by leaders in other fields of endeavor. Much has been accomplished in this line of work during the past few years but there is still a great deal to be done.

A criticism which has frequently been levelled against our profession—and one which we cannot well deny—is that we tend to rely too strongly upon our ability to diagnose and treat the case. We who have been trained in the art of consultation have, in this instance, appeared to have gone back on our training.

The problem of providing and improving medical care is of prime concern to the physician, but it is also of importance to the industrialist, the labor leader, the small business man, the farmer, the insurance companies, the hospital administrator, the public health official, the social welfare worker, and above all—to the individual who needs medical care. Our greatest advances will be made as we consult and cooperate with these individuals and groups in working toward the common goal of good medical care for all of our people.

Let me tell you of an experiment we are making in my state, to illustrate my point. Medical leaders in South Carolina had realized for years that there was much to be done in that state toward improving conditions in the field of medicine, but no one seemed to know just what our state medical association should do in the matter. In November 1943, a group was invited to a dinner. Those present consisted of two industrialists, the head of an old line insurance agency, the president of our state hospital association, the dean of our medical college, a member of the executive committee of the state board of health, the chairman of our council, a general practitioner, an internist, a surgeon, and myself. Following the meal, this question was presented for discussion, "What should be done about medical conditions in South Carolina?" There was much talking, and various ideas and suggestions were presented, but as is usual in so many discussions of this type no definite conclusions were reached. Finally, someone remarked, "What we need is a



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definite plan embodying the various suggestions made here tonight." Assembling the opinions and ideas which had been expressed, a ten point plan was evolved.

Now that we had something definite to present, we invited a larger group to another conference in the capital of the state. In this group were a few physicians and a large number of representatives from non-medical groups including industry, and the press. The ten point plan was considered point by point and sentence by sentence. Various changes were made but so cooperative was the group that there was unanimous approval of the final draft.

Our next step was to determine the attitude of the average physician toward the plan, so it was presented to one of the largest county medical societies for consideration. Here again there was full discussion with eventual approval.

Then and only then did we feel ready to submit the plan to the House of Delegates for adoption. After study, the House of Delegates adopted the plan and on September 1, 1944, the Ten Point Program of the South Carolina Medical Association was put into action with wide newspaper and radio publicity. (Just as a note of historical interest, this was the first plan of its type to be adopted by a state medical association. Since then other states have presented their plans and the American Medical Association now has its Ten Point Program.)

What have we learned from our 22 months of experience? We have come to realize the value of a clear-cut program of action. It not only shows the people of our state just where we stand and what we advocate for the future, but it also serves as a guide for the activities of our association. We have convinced ourselves anew that the problem of furnishing good medical care can and should be dealt with on the local and state level rather than on a national level. We have learned the fundamental need for consultation and cooperation with others. We know that the problem of providing and improving medical care for the people of South Carolina is one which our association alone will never solve. It is a task which will require the mutual study and cooperative effort of physicians and of leaders in other walks of life. And finally, in spite of our mistakes and failures, we are certain that the method which we are employing is the greatest single force which can be used in our fight against the imposition of a federal, political system of medical care upon the people of America.

I have described our experiment in South Carolina merely to show what one association is doing and to recount the lessons which have been learned. I know that there are other associations, more far-sighted and more active than ours, who have made far more progress than we have. I also know that there are some associations who still seem to believe

that the way of isolationism is the best way and they continue to carry on their activities as they did twenty years ago.

Progressive or regressive, every state association needs constant stimulation and helpful criticism from an organization such as this. And here are three specific ways in which this Conference can be of service.

First, we can continue to make our annual meeting a model one by inviting leaders in other fields of endeavor to address us. Last year we were privileged to hear Mr. A. J. Altmeyer, Chairman of the Social Security Board, and Mr. John F. Hunt, Vice President, Foote, Cone, and Belding, Chicago. This year we are to have the pleasure of hearing from Mr. Upton Close, noted writer, commentator, and news analyst. These men are not only clear thinkers and forceful speakers, but they have had the opportunity of viewing our problems from a distance. They see our strength and they see our weakness—and being honest and sincere, they tell us about them. This is what we need. It will help to eradicate one of the great defects in our profession today—the belief that physicians and medical organizations are omniscient in the field of medical care.

Secondly, this Conference can encourage our state medical associations to enter into discussions or to continue discussions with individuals and groups outside of our profession who are vitally interested in the welfare of our people. From these discussions will come a new vision of the needs which exist and the possibilities for the future.

Finally, we can encourage every state association to adopt a comprehensive, progressive, and aggressive program of action. Such a program should be given wide publicity so that the people in every state will know that the medical profession is still out in front where it should be in the great fight for better health.

My third suggestion to this Conference is that it stimulate our state and national associations to encourage more activity and participation in medical affairs by the rank and file of our profession, with particular reference to our younger physicians.

Let me describe two hypothetical men. Dr. Jones Roberts, as I picture him, is usually a specialist although in rare instances he is a general practitioner. He is an older man, comfortably fixed financially, with either an associate or an assistant to carry on his work while he is away from his office. He attends state, sectional, and national medical meetings and has held an important office in one or more of these organizations. He is acquainted with medical leaders over the country. He is well known outside his profession and his voice carries a certain amount of weight in state and national legislative halls.

Dr. Robert Jones, usually known to his friends as plain Bob Jones, is a younger man. He may be



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either a specialist or a general practitioner and has probably seen military service during the last war. The pressure of his practice and his financial obligations keep him working day and night. He attends local and, usually, state medical meetings. Once every few years, he goes to a regional or national gathering. He knows many of the medical leaders in his own state, but those from other states are to him merely names in print. His voice carries little weight in legislative halls but he is well acquainted with his local congressman or his state senator. He understands the medical problems of his own community and he has developed his own ideas as to how they could be solved. But little opportunity is given for him to express his opinions, much less to try to put them into effect, so he goes his way caring for his patients.

In my opinion, our state and national associations have relied too heavily upon Dr. Jones Roberts, forgetting that for every Dr. Jones Roberts there are a hundred Bob Joneses, and that the work of Dr. Jones Roberts would amount to nothing if it were not founded upon the daily work of Bob Jones and his colleagues.

What does Bob Jones see as he contemplates the work of medical organizations today? He sees medical associations which in theory are built upon democratic principles with equal rights and privileges for all, but which in practice are dominated and directed by Dr. Jones Roberts and his associates. Two courses appear to be open to Bob Jones as he contemplates work in the organization—he may serve a long period of apprenticeship in the hope of some day crashing the inner circle or he may turn away in disgust with the statement, "Let the big boys run it if they want to, I'll do something else." Since Bob Jones frequently adopts the latter attitude, is there any wonder that we fail to get his support in many of our activities?

A recent study which I have made will illustrate my point. It deals with the House of Delegates of the American Medical Association, which is frequently criticized by Bob Jones for being a closed corporation of older men.

First, I determined the ages of the members of the House of Delegates who attended the meeting in Chicago last December. Fourteen percent of these men were over 70 years of age, twenty-six percent were over 65 years of age, and seventy percent were over 55 years of age. There were only fourteen and a half percent under 50 years of age. Considering them as a group, the average age was 62.3 years. Contrast this with the average age of state medical association presidents for 1945—fifty-seven years. Bob Jones may be justified in calling the House of Delegates of the American Medical Association a group of older men.

But is the House of Delegates a closed corporation? Dr. George Lull, Secretary of the American

Medical Association, was kind enough to send me a list of the members of this year's House of Delegates with the number of years each member had served in that body. The data is relatively complete since it gives the record of 169 men. Of this number 26 will be fledglings, coming for the first time. 59 will have served from one to five years, 39 from five to ten years, 32 from ten to twenty years, and 13 will have been members for over twenty years. The average length of service, listing the fledglings as having served no years, is 6.2 years. Bob Jones may not be justified in calling this body a closed corporation but he can easily convince himself that there is not much chance for a younger man in an organization which only adds 15% new members a year while 26% of the members have served for over ten years.

The condition which prevails in the House of Delegates of the American Medical Association probably prevails in many of our state associations' executive bodies and committees. It know it holds true with regard to state association secretaries and editors.

I would be the last one to decry the fine contribution which Dr. Jones Roberts has made to the progress of our profession. But I would also be the last one to advocate the principle of the indispensable man, whether it be in politics or medicine. Old blood, with its wisdom and stability is essential to our work, but so is new blood with its vigour and forward look.

What can this Conference do to bring about a transfusion of new blood into our various organizations and associations? It can suggest to the presidents and presidents-elect here today that they remember Bob Jones as they make their appointments for the coming year. It can suggest to our elective bodies that they consider well the choosing of younger men as leaders and as representatives to official bodies. And it can suggest to legislative bodies, including the House of Delegates of the American Medical Association, that a limitation of a certain number of years be placed upon any member's tenure of office.

My final suggestion to this Conference is that it promote a better exchange of information and ideas between the various state medical associations.

Over the years, each state association has carried on its program of activities. Through trial and error, through achievements and mistakes, each association has amassed a wealth of data and a fund of experience. Although each association has dealt with the affairs of its own state, the problems are not necessarily peculiar to a given locality but are frequently the common problems of a section of the country or of the country as a whole.

Knowing the value of consultation, it is only natural that each association should want to know what is going on in other states. Out of this desire have come regional and national conferences, ex-

change of official publications and news letters, personal correspondence and conversations. All of these have proved their worth, but they are not sufficient. Some method of procedure should be devised whereby any association can have ready access to the information and experience accumulated by its sister organizations.

Toward this end I suggest the establishment of a central office which shall serve as a storehouse of information and a clearing house of ideas for state associations. In charge of this office would be a full time executive who is thoroughly grounded in the work of state medical organizations. It would be his duty to assemble pertinent information from the various state societies and to keep this on file. As requests came in, he would furnish information to state associations as to what other organizations had done or were planning to do in a given field. Upon invitation, he would visit the various state associations for conferences and discussions. In brief, he would be the contact man—a liaison officer, if you please, between the state medical associations of this country. As a secretary, I can testify to the great need for such an individual in a central office and it takes but little imagination on my part to visualize the amount of good which he would accomplish and the value of his work to our various state organizations.

Who could establish such an office with such an executive director? As I see it there are two possibilities—and these I present for the consideration of this Conference.

A new office could be established within the framework of the American Medical Association, and the director might well be called the Under-secretary for State Medical Associations. With an office in the headquarters of the American Medical Association, the director would have the vast amount of information already assembled in that organization at his disposal. And being in close contact with the Secretary of the Association, the Editor of the Journal, the executive officers of the various boards and councils, he would have the benefit of their knowledge and experience.

A second possibility would be for this Conference to establish such an office. Since the director would be concerned with assembling and dispersing information and would not be concerned with establishing or administering policies, his work would be in direct harmony with the spirit of this organization. To operate such an office would require a certain amount of money but I feel sure that this could be secured from the participating state medical associations.

In conclusion, I wish to express again my sincere appreciation to the Executive Committee for inviting me, a state secretary, to appear on the program, and to utter the hope that at subsequent meetings of this Conference other secretaries, medical and executive, will be afforded the same privilege.

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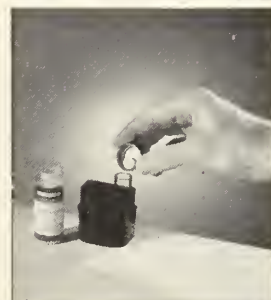
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NEWS ITEMS

There will be a joint meeting of the North and South Carolina Eye, Ear, Nose, and Throat Societies in Hendersonville on Sept. 16 through 19. The first two days will be devoted to Ophthalmology and the last two to Otolaryngology.

The following speakers are scheduled to appear:

Dr. A. B. Reese, Assoc. Prof. of Ophthalmology, Columbia Univ.

Dr. Paul Chandler, Instructor in Ophthalmology, Harvard Univ.

Dr. Frank B. Walsh, Asso. Prof. Ophthalmology, Johns Hopkins.

Dr. William L. Benedict, Mayo Clinic.

Dr. C. H. McCaskey, Prof. of Otolaryng., Univ. of Indiana.

Dr. O. E. Van Alyea, Asst. Prof. of Otolaryng., Univ. of Ill.

Dr. J. M. Smith, Surgeon, N. Y. Eye and Ear Infirmary.

TWENTY-FIFTH ANNIVERSARY OF THE DISCOVERY OF INSULIN

The twenty-fifth anniversary of the discovery of Insulin will be observed with a program in Convocation Hall, at the University of Toronto, on September 16. Many internationally known figures in the field of medicine will be present to honor the occasion. Among them will be R. D. Lawrence, physician in charge, Diabetic Clinic, Kings College Hospital, London, England; H. C. Hagedorn, of Gentofte, Denmark; Bernardo A. Houssay, Research Institute of Experimental Biology and Medicine, Buenos Aires, Argentina; and Elliott P. Joslin, Harvard Medical School, Boston, U. S. A. This observation will be followed by the regular annual meeting of the American Diabetes Association.

On September 23 Eli Lilly and Company will sponsor an International diabetes clinic to be held at the Indiana University Medical Center in Herty Hall of the State Board of Health Building, Indianapolis, Indiana. International importance will be given to this meeting by the presence of Professor Charles H. Best, Toronto, Canada, co-discoverer with Banting of Insulin, Professor Houssay, Dr. Lawrence, and Dr. Hagedorn. They will discuss various phases of diabetic care.

Reservations already received for the convention of The Association of Military Surgeons of the United States to be held in Detroit on October 9th to October 11th inclusive, indicate that attendance this year will be unusually heavy. Therefore, all members planning to take part in the convention are urged to send in their reservations immediately so as to be sure of obtaining proper hotel accommodations. Dr. Carleton Fox, general convention chairman, announces that Lt. General Walton H. Walker, Commanding General of the Fifth Army, has accepted an invitation to serve as honorary chairman. Other members of the honorary committee are General Bliss, U. S. Army; Captain Cole, U. S. Navy; Dr. Williams, U. S. Public Health Service; and General Hawley, Veterans Administration, who will serve as

vice chairman.

The convention will formally open Wednesday morning, October 9 at 10:00 A. M. in the ball room of the Book Cadillac hotel. Addresses of welcome will be delivered by Edward J. Jeffries, mayor of the city of Detroit; Dr. W. B. Harm, president, Wayne County Medical Society; Dr. Louis Broom, president, Detroit District Dental Society; and Dr. James E. Patterson, president, Southeastern Michigan Veterinarian Association. Highlighting the initial session will be the presidential address delivered by Col. Ervin Abel, president. The Association of Military Surgeons of the United States, and the addresses of the Surgeons General, by Major General Norman T. Kirk of the U. S. Army; Vice Admiral, Ross T. McIntire of the U. S. Navy; Dr. Thomas Parren of the United States Public Health Service, and Major General Paul R. Hawley of the Veterans Administration.

Atlanta, Ga.—Appointment of Dr. R. Hugh Wood, physician-in-chief at the Emory University Hospital, as dean of the Emory University School of Medicine, has been announced by Dr. Goodrich C. White, Emory president. Dr. Wood succeeds Dr. Eugene A. Stead, Jr., who resigned recently to accept a position at Duke University.

A native of Virginia, Dr. Wood received his medical training at the Medical College of Virginia in 1921. He completed his internship at St. Elizabeth and Memorial Hospitals, Richmond, Va., and Peter Bent Brigham Hospital, Boston, Mass.

In 1924, Dr. Wood came to Atlanta as resident physician in the Emory Division of Grady Hospital. After two years in that position, he entered private practice in association with Dr. James E. Paullin. This association continued until 1934, when he began independent practice of internal medicine.

Dr. Wood was commissioned as an officer in the Army Medical Corps in 1942. Appointed chief of medical service for the 43rd General Hospital (the Emory Unit), he served with the hospital in North Africa and Italy. Returning to the United States late in 1944, he served for a few months at Fort McPherson and was then named Chief of Medical Service at Lawson General Hospital, a position he held until his release from active duty in October, 1945. He left the Army with the rank of Colonel.

Long an outstanding practicing physician, Dr. Wood has been associated with the faculty of the Emory medical school since 1924, when he was first appointed an instructor in medicine. Upon his return to civilian life, he became associate professor of medicine in the medical school and physician-in-chief of the Emory hospital.

Dr. James Boyce Pressley has formed a partnership with his uncle, Dr. W. L. Pressley, of Due West, S. C. He has just returned from 40 months service in the Army in Japan and other points.

Dr. J. W. Kitchen has returned to Liberty to take up his former practice of medicine. Dr. Kitchen has served with the Army in Germany and Italy for the past two years.

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*Hinsie, Leland E.: *The Person in the Body, an Introduction to Psychosomatic Medicine*, New York, W.W. Norton & Co., 1945, p. 223.

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Dr. William T. MacLauchlin, of Great Falls, plans to go to Conover, N. C. early this fall, where he will form a partnership with his friend, Dr. Charles Cloniger. Dr. MacLauchlin was separated from the service recently with the rank of Major.

Announcement is made of the marriage of Miss Virginia Mason, of Fort Worth, Texas, and Dr. Charles Brannon Thomas, of Florence, which took place July 22 at the First Presbyterian Church in Fort Worth.

BIRTH ANNOUNCEMENTS

Dr. and Mrs. Joseph E. Crosland announce the birth of a son, Joseph E., Jr., on Friday morning, July 26, at St. Francis hospital, Greenville.

Dr. and Mrs. David Wilson of Greenville announce the birth of a son, Robert Alexander, on August 1 at Duke University Hospital in Durham, N. C.

Dr. and Mrs. Robert Stith of Florence are receiving congratulations upon the birth of a daughter, Finlay, on August 19, at the McLeod Infirmary.

Dr. and Mrs. Marshall Coleman have announced the birth of a son, Marshall, Jr., on August 21. Dr. Coleman has been practicing in Darlington since his release from the Army.

BOOK REVIEWS

The Management of Fractures, Dislocations, and Sprains. John Albert Key, St. Louis, and H. Earle Conwell, Birmingham. C. V. Mosby Co. (St. Louis)

This is the fourth edition of a book which has become one of the standards in the field of orthopedics. In this edition, much that is new has been added—thanks to the lessons learned during the war and in the natural development of science. The principal changes are to be found in the sections on the spine, the hip and compound fractures.

Since the book is written as a guide in the management of fractures, dislocations, and sprains, it is only natural that the authors should include a chapter on The Workmen's Compensation Law affecting fracture cases and also one on the Medicolegal Aspects of Fracture Cases. These two chapters in themselves, particularly the section headed "Avoidance of Malpractice Suits," should save the reader more than enough to compensate him for the cost of the book.

medicine and surgery, and the appreciation of his remarkable contribution will grow greater and greater as the years go by," so wrote Dr. Thomas S. Cullen in Jan. 1945.

Before his death, Mr. Brodel became intensely interested in the problem of good illustrations of the anatomy of the human ear. He planned three comprehensive drawings. Two of these were completed, and the third was in the stage of preliminary sketches based upon his research studies. This latter drawing has been completed by one of his former pupils, Mr. P. D. Malone. The three drawings are now presented in this special volume as a tribute to the memory of Max Brodel by the publishers, W. B. Saunders Company.

Every otologist and every lover of medical art should be proud to possess this volume.

Three Unpublished Drawings of the Anatomy of the Human Ear. By the late Max Brodel. Assisted by P. D. Malone, Stacy R. Guild, and S. J. Crowe.

"Max Brodel was born on June 8, 1870, and died on October 26, 1941. During his span of life he revolutionized medical illustrating and places it on a very high plane. His pioneer work in medical illustrating has already been of inestimable value to

Synopsis of Pathology. W. A. D. Anderson, Professor of Pathology and Bacteriology, Marquette Univ. School of Medicine. C. V. Mosby Co. (St. Louis)

This is the second edition of a book which was written "to fill a gap between the very elementary manuals of pathology and the abundant excellent larger text-books and reference works." Highly readable, well illustrated, compact and yet comprehensive, this volume should serve as a handy book for the medical student and for the practitioner who desires to keep in touch with the fundamentals of pathology.

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52



The Journal of the South Carolina Medical Association

OCTOBER, 1946

VOL. XLII, NO. 10

Article	Author	Page
Some Common Proctologic Conditions of Childhood	Louis J. Hirschman, M.D.	267
The Medical Treatment of Gall Bladder Disease	John A. Boone, A.M., M.D.	272
The Public Health, the Politician, and the Doctor	Lowell S. Goin, M.D.	274

Editorials — The Ten Point Program — Public Health News — News Items — Deaths
Woman's Auxiliary — Book Reviews

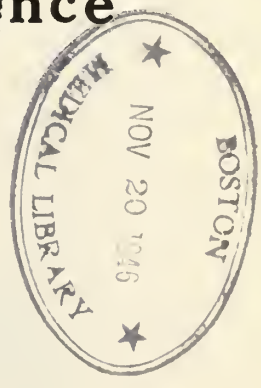
BACKGROUND

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1. Am. J. Dis. Child. 66:1 (July) 1943.

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U P J O H N V I T A M I N S

OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

October, 1946

NUMBER 10

Some Common Proctologic Conditions of Childhood

LOUIS J. HIRSCHMAN, M.D.
Professor Emeritus of Proctology
Wayne University, Detroit, Michigan

Unless one gives some thought to the subject, a discussion of the relationship between Proctology and Pediatrics might seem somewhat remote. As a matter of fact, it is amazing, particularly in the private practice of proctology, how many patients are below the age of twelve years.

If one were to treat of the full subject—that is, to discuss all of the proctologic affections from which children suffer, it would be possible to consider only a small percentage of these diseases in the time allotted to this presentation.

Inasmuch as I have been requested to treat of a few of the commoner proctologic diseases of childhood, I am forced to omit any discussion, save by mention, of congenital defects such as various atresias and megacolon, as well as intussusception, procidentia, Meckel's diverticulum, multiple polyposis, sarcoma and other diseases affecting the anus, rectum and colon as well as major injuries and the various types of parasitic, bacillary, and infective types of proctocolitis.

Even the commoner diseased conditions affecting the anus, rectum and colon of children are so numerous that in order to conserve our time only a few will be mentioned.

The child is usually brought to the proctologist either by reference from the pediatrician, the family physician, or directly by the parents.

Any patient, whether child or adult, consults the physician either because of physical suffering or apprehension. Discomfort may range from simple irritation, to the most severe type of pain. Apprehension is usually caused by some disturbing change from the normal physiologic trend of the patient's habits. Irritation, pruritus, localized tenderness, tenesmus or sphincter spasm, burning, throbbing,

boring stabbing, intermittent or continuous pain may be mentioned, as well as severe pressure and colicky cramp-like pains.

Symptoms which, on the other hand, cause apprehension may include changes in bowel function or in character, such as frequency of movements, constipation, obstipation, obstruction and the appearance of various types of discharge at the anal orifice such as mucus, serum, blood, pus, liquid feces, or the discovery of some type of intestinal worms.

Not infrequently mothers will bring their children to you with the story of soiled diapers or drawers. The soiling may be bloody in character or merely a fecal stain. It is quite amazing, however, how complacent some mothers seem to be, when symptoms which do not cause actual suffering are observed.

I have seen young children with enormous abdominal distension, in some cases caused by true and some from false megacolon, where the mother seemed to think that it was merely evidence of an increase in weight or adipasis.

Congenital Conditions

While I do not intend to discuss congenital absence of the anus, anal canal or rectum, I feel that I must repeat this admonition to all physicians attending obstetrical cases. As soon as possible after the child has been born, the cord tied and the safety of the mother assured, the child should be examined carefully for any deviation from the normal. I had supposed that was an invariable rule and yet, in my own experience, on several occasions, infants have gone several hours up to two days without complete or partial atresia being discovered.

I had a recent incident where the accoucheur happened to be the uncle of the child. The delivery was delayed two or three days beyond the expected time and he had made arrangements to go hunting. The day of his departure he delivered his niece and as soon as he could take off his gloves and wash his

*Presented at the Annual Session of the S. C. Medical Association, May 1, 1946, Myrtle Beach, S. C.

hands, he turned the case over to the resident and left for his trip. Had he spent a few moments more hunting for abnormalities on his niece rather than hunting for game birds he expected to shoot, he would not have been placed in the embarrassing position of failing to note the complete absence of the anal aperture in his own niece. A whole day lapsed before the nurse noticed that there were no soiled diapers. When I was called, it was necessary to perform an emergency colostomy to save the child's life. (Slides)

Impaction

Another congenital condition which, I think, should be mentioned in passing, is the occasional appearance of a true megacolon, or Hirschsprung's disease. Most of the little patients that we see on which such a diagnosis has been made are, however, suffering from pseudo-megacolon or "acquired Hirschsprung's disease." Through dietetic errors and improper feeding, these little patients gradually acquire an accumulation of fecal material as a result of improper and incompleting evacuations.

Although the mother reports a good movement each day, there is some stool remaining. This becomes impacted due to the daily accretions until the colon gradually becomes over-distended from the presence of these impactions. The child still continues to pass varying amounts of stool daily and, gradually due to over-distention, impairment of sphincter function develops, and there is a leakage of mucus and liquid stool which passes by and around the impactions and causing soiling of the clothing.

If the child is of school age, he is sent home and often may be punished on account of the ignorance of both teacher and parent of the true condition. The mother eventually discovers that the little patient has gradually increasing abdominal fullness, and he is brought in for examination.

It is amazing how much impacted stool can accumulate in a child's colon. Injection of barium and roentgenological examination show an enormous distension of the colon and a diagnosis of Hirschsprung's disease is apt to be made.

However, after evacuation of the impactions, succeeding colonograms will show gradually decreasing colonic caliber and eventually, by correction of dietary errors and improvement of intestinal habits, the condition is entirely relieved. (Slides)

Many cases of fecal impaction are of a much less severe degree and may be merely transitory in character. The little patient may be erroneously thought to be suffering from diarrhea on account of frequent passages of liquid stool or stool stained with mucus, but this leakage is caused by the irritation of the lower portion of the colon and the rectum by the presence of the hard stercoral masses.

We have found that the best method for disposing of fecal impactions not only in children but also in adults, is by the administration of an enema consisting of from a 10 to 30% solution of Peroxide of Hydrogen. This disintegrates the impaction so it usually can be passed either by the patient unassisted or following the administration of a sodium bicarbonate enema.

In some cases where the impaction is of dense consistency, it may be broken or at least tunneled by the insertion of a long hemostatic forcep which perforates the impaction. Then the forceps may be opened in several directions. The impaction can then be loosened up and broken into smaller masses, and easily passed or removed.

In some cases where the impaction is simply canalized, a No. 26 rubber catheter or rectal tube can be inserted through the anoscope and into and sometimes through the channel. The peroxide solution is then administered and the disintegration of the impaction is greatly accelerated. (Slide)

In some cases the presence of impaction causes obstipation. In these cases the treatment is the same—first the removal of impaction and then institution of the proper measures for correction of bad dietary and intestinal habits.

Polyposis

One cause of apprehension and alarm on the part of the mothers is the appearance of blood either accompanying or following a bowel movement. This bleeding may come from various sources. The most common source of bleeding in infants and children is the presence of one or more polyps. If the little patient is afflicted with a single polyp, the treatment is not especially difficult. The diagnosis is usually made by a history of rather small amounts of blood appearing either at the time of passing or following the stool. It is almost always bright red or fresh in character and its passage not accompanied by pain.

If a single polyp of fairly large size happens to be located in the ampulla and is attached by a fairly long pedicle, it may be extruded with the stool. The mother will usually describe it as a dark red, rounded, somewhat spongy mass, as a rule. Its reduction is rather easy as the polyp snaps back into the anal canal on digital pressure. The treatment, of course, is surgical.

In children, it is usually advisable to use inhalation anesthesia. Instead of transfixing and double ligating the pedicle, as so advised in many text books on general surgery, it is much better to excise the entire pedicle and base. We ligate the blood vessels, starting above as indicated, when the first ligature is placed before we excise the base. This usually controls most of the bleeding.

The aftercare is very simple, the patient being allowed to be up and around after the first twenty-four hours—the bowels controlled by diet and sodium

bicarbonate enemas for the first two or three days, after which the patient resumes his normal mode of life.

Multiple polyposis is a much more serious problem and usually is best taken care of by the specialist rather than by the general practitioner.

Multiple polyposis is frequently familial. Careful studies made of these cases have shown that in at least two family groups as many as fifteen cases have been noted. The prognosis usually is not very good, particularly if the polyposis extends above the recto-sigmoidal juncture. Symptoms of frequent bowel movements containing blood, both bright red and darker in color mixed with stools and accompanied by large amounts of mucus, characterize this disease. Patients look anemic and show evidence of loss of weight and the hyperperistalsis is difficult to control. The treatment of these severe colonic cases usually includes a partial or complete colectomy. The tendency to malignancy is great.

In those cases of multiple polyposis where a few polyps are located in the rectal ampulla, they can be removed by ligation, the electric snare, or, in suitable cases, destroyed by fulguration.

Prolapse

Another cause for apprehension on the part of the mother is prolapsus. She is apt to call her physician or pediatrician, in great distress, stating that the child's rectum is protruding. The appearance of a prolapsus is quite characteristic.

A ring of red or dark purplish mucous membrane is seen extruding from the anal orifice. It may or may not bleed. It is soft in texture and usually not lobulated unless hemorrhoids are present and then the lobulations are just inside of the skin margins. The prolapsus is ordinarily reduced with ease, particularly if the little patient is inverted. Prolapsus often accompanies a polyp, particularly if the polyp is large, but it may occur from congenital weakness of the rectal supports.

In infants, this condition is often corrected by making the child move its bowels in a reclining position instead of placing it on the infant's toilet seat and allowing it to remain there for varying lengths of time endeavoring to produce a movement.

Sometimes the use of a special longitudinal aperture instead of the circular opening of the toilet seat will give support to the buttocks of the child so that he will not be so apt to extrude the prolapse. It is very rarely necessary to perform any type of surgical operation for the relief of prolapse in children unless there is a complete procidentia of the rectum. (Slide)

The worst case that occurred in personal practice was one seen a number of years ago. In this child a complete intussusception of the entire colon occurred so that the cecum extruded from the anus. It is not my intention to discuss intussusception today.

In our hands, linear radial cauterization has proved extremely helpful in the relief of prolapsus in infants and children. A general anesthetic is administered, of course avoiding any explosive types. The prolapsus is then reproduced and usually from four to six lines of cauterization are made.

One must be very careful not to cauterize down to the transiderm which merges the mucous membrane to skin, as stenosis would surely result. The same caution must be observed in the rectal ampulla so that the lines of cauterization are not brought too closely together. One must be extremely cautious. The burns should be carried through the mucosa only to the musculature and one must be extremely careful, particularly on the anterior surfaces so that injury to contiguous organs or perforation into the peritoneal cavity do not occur.

Foreign Bodies

Children are prone to put all sorts of things in their mouths, either edible or not, so that every year we are called upon to treat quite a group of these little ones for the effects of trauma to the anal canal and rectum caused by various objects which they have swallowed. Occasionally they are brought to us suffering from foreign bodies which have been inserted intentionally or accidentally into the rectum. In most of these children, however, these foreign bodies are quite small and are usually swallowed with the food.

In others, articles such as marbles, coins, small metallic toys, pebbles, etc., are placed in their mouths, as children will do, and are inadvertently swallowed. In most instances, foreign bodies which are smooth and rounded will be passed within twenty-four or forty-eight hours without causing other damage than an over-distention of the anal sphincters.

This will cause painful movements for a few days and occasionally a streak of blood will be seen on the stool or on the toilet paper. After the little patient has gotten over his apprehension regarding a bowel movement, his condition will usually return to normal.

In some instances, small swallowed objects such as bits of bone, egg, shell, sand, bits of glass and other irregular and rough articles will become embedded in the stool mass and, during extrusion, will scratch, cut or excoriate the anal canal. Oftentimes these particles become engaged in one or more crypts of Morgagni where they may traumatize the parts and infection and injury follow.

As a result of the pain and tenesmus, the little one resists the peristaltic urge and will cry out from the severe pain which is caused by an attempt at defecation. Not infrequently severe impactions develop following resistance to defecation. As a result of infection, the little one will run a temperature and, on account of his refusal to eat and often to drink, becomes dehydrated. Added to this is irritability, crossness, and suffering of the little patient

which intensifies the apprehension felt by the parents.

An examination of the ano-rectal region quickly assists in making a diagnosis. In order to make this examination in older children, the injection of a local anesthetic agent, such as a half per cent solution of metycaine, is sufficient to relax the sphincters so that an anoscope is passed, when the foreign body can be seen and removed with forceps.

In young children or those apprehensive, nitrous oxide, with or without ether, should be the anesthetic of choice. It is our practice, after the removal of small foreign bodies, to incise the affected crypts or other wounds, carrying the incisions down to the skin surface for drainage.

Impactions, if present, should be removed at the same time and the child should be given bulk water-carrying laxatives and other treatment for the relief of constipation which has ensued. Larger foreign bodies sometimes pass through the entire gastrointestinal tract and cause symptoms only when they reach the ano-rectal juncture.

Many objects could be enumerated which have been swallowed and have been recovered through the anoscope. A short time ago a mother, in great distress, telephoned me stating that her little two-year-old had been gorging herself on that well-known product of the Southern States—peanuts. She said, "Little Ann ate so many peanuts that she became nauseated and vomited a large quantity of them yesterday and today she refuses to go to the toilet and I cannot examine her because every time I touch her near the anal opening, she screams with pain. I think there must be a nut lodged there." The mother brought the little patient to my office and, under light anesthesia, I inserted my little finger and, sure enough, I found a nut lodged in the anal canal with the sphincters tightly contracted around it. But—it was not a peanut—nor a pecan, nor a walnut. It was a square nut made of iron from a bolt from the bottom of the baby's crib. The child had been crawling under her crib, picked up this nut from the floor, swallowed it and apparently it was lost in the stomach full of other mixed nuts which she had ingested and, on account of its shape, size and consistency could not be passed as were those of the more edible variety.

One might say that this child committed two errors in judgment . . . one in swallowing the wrong kind of nut and the other in taking too large a dose of iron at one time.

Sometimes children insert objects into the rectum such as pebbles, beans, sticks and other articles, and when peristalsis is stimulated the on-coming stool forces them against the upper and nearer surface of the ano-rectal juncture and sometimes into the crypts, and occasionally the mucous membrane is perforated and infection may result.

We find the simplest way to handle these cases is again to relax the sphincters, under local anesthesia, to lift the swallowed object up out of the crypt or wound and then withdraw it. This, I call, the "fish-hook" technique.

Several times little patients have been sorely distressed when enema tips have become detached and have disappeared up into the rectum and then forced down by peristalsis, thus causing similar symptoms. We have had to remove some of these.

We advise mothers to use soft rubber catheters so as to avoid injury by the tip when inserted into the rectum, or, if it should become detached and act as a foreign body.

A distraught mother called me by telephone one afternoon stating that she thought a thermometer with which she was taking her little one's rectal temperature had disappeared into the rectum. Her story was that the baby seemed to be feverish and her pediatrician requested her to take the baby's temperature by rectum. She inserted the thermometer with the baby lying on her side in her crib. She heard a crash in the next room—one of the other children upset some chinaware—she rushed in to rescue what remained of the dinner set and then returned to the little patient. The thermometer had disappeared! She searched the crib and the nursery but could not find any trace of it. Greatly distressed she again called her pediatrician who referred her to me. I examined the little patient and—sure enough—there was the thermometer. Fortunately it was unbroken and I removed it by the fish-hook technique. I then called the pediatrician and was able to tell him the temperature of his patient was 102.8, which, of course, relieved everybody!

Children, after all, in many instances, are but adults not completely matured. They are subject to the majority of diseased conditions which affect their elders. It is not uncommon to find children suffering from internal hemorrhoids. Acute thrombotic hemorrhoids, however, do occur more frequently.

Hemorrhoids

During an epidemic of upper respiratory infections, particularly in children who have been victims of measles, bronchitis, or whooping cough, acute thrombotic hemorrhoids or peri-anal hematomas may be caused by the traumatic rupture of anal veins as a result of severe coughing, sneezing or vomiting attacks.

Thrombotic hemorrhoids are, of course, immediately recognized by their sudden appearance and bluish or purplish color and they are located right at the anal margin and almost always are external. Occasionally internal thrombotic hemorrhoids may accompany the external ones and more rarely may occur alone.

The treatment is surgical, as a general rule. In some instances, continuous applications of a hot saturated solution of magnesium sulphate on cotton compresses will cause a gradual reduction of the swelling and, occasionally, will entirely relieve the condition.

Abscess

When this happy end is not accomplished, sometimes the clots become organized due to pressure and may cause localized areas of necrosis. In other instances, infection of the clot will occur and perianal abscesses will develop from this source. Just recently I had such a case in a twelve year old girl where the abscess developed rapidly and involved the entire right buttock, requiring radical surgery for its relief.

Where abscesses rupture spontaneously, fistulas, either complete or incomplete, may occur. These follow the usual course in children as in adults and require a similar type of surgical relief. I may state in passing, however, that we do not believe in the complete division of the external sphincter muscle in fistula or other anal surgery, either in children or adults.

We are called upon too frequently to perform plastic operations for the restoration of sphincteric function in patients who have had their sphincters divided, to ever indulge in such a practice in our own practice.

When an abscess is diagnosed, it should be punctured immediately in order to relieve tension and pain and to arrest the progress of the disease.

The parent should be told that this puncture is merely a temporary relief measure and that the complete operation for the ultimate cure of the abscess must be performed under proper hospital surroundings. One should puncture the abscess immediately on recognition because oftentimes what might be rather an extensive operation becomes one of much less severity because of contraction of the abscess cavity after the pus has been evacuated.

I must confess that I am not in sympathy with those who advocate large doses of Penicillin without surgical relief of an abscess, whether located in the ano-rectal region or anywhere else. While Penicillin is a wonder drug and does wonderful things in connection with infection, it still is not a substitute for good surgical drainage of an abscess cavity and it certainly does not prevent complications resulting from the rupture of a peri-anal or a peri-rectal abscess into the vagina, bladder, or other adjoining organs. Moreover, immediate evacuation relieves pain and pressure necrosis, which is a very important consideration.

Anal Fissure

One of the most important conditions which should be discussed in a paper of this type is one which is most often overlooked.

Too often the little patient is brought to the pediatrician or family physician with the story that

he resists, squirms, and fights against being placed on the toilet seat. After he does have a movement, he cries bitterly and shows every evidence of pain and suffering. As a result of the memory of painful movements, he resists succeeding ones and becomes constipated and often impacted.

If the mother or the nurse is alert, a small smear or stain of blood will be noticed on the toilet paper. If such is the case, one may be reasonably sure that the little patient is suffering from an anal fissure.

Fissures are quite common in infants and small children where, on account of improper feeding habits or lack of attention to bowel hygiene, constipation or impaction results. These fissures in contradistinction to those in adults are more often definite splits in the transiderm due to over-distention rather than to the tearing down of anal papillae.

Examination will disclose a little red furrow, most often in the posterior wall of the anal canal, and, not infrequently, leading out onto the skin where a sentinel pile may be noticed.

In most of these children, the injection of 2 or 3 cc. of a 1-10% solution of Eucupin-in-oil, or 1/2% solution of Quinine Urea in Brocaine solution, or the same strength of Diothane solution, will put the parts at rest.

A point immediately behind or below the outer extremity of the fissure is selected, and the solution of choice is injected under the fissure and to its upper limit.

In quite a number of instances this is all that is necessary, because the long-lasting anesthetic acts as a splint for the fissure, putting it at rest. Then, with proper attention to the bowel movements so that neither watery nor constipated stools are passed, healing progresses in a very satisfactory manner.

In other instances, it is necessary to incise some of the sphincter fibers. If the child is old enough and can be persuaded that he will suffer no pain, a local anesthetic can be used. In infants and in apprehensive children, light inhalation anesthesia should be employed.

After the incision has been made, the sphincter should be massaged, but, under no circumstances, should it be divided so that sphincter fibers are torn.

It is not necessary to pack the canal after this operation. In fact, I do not think it is ever necessary to pack unless, in rare instances, bleeding is incurred as in a hemophiliac.

The postoperative care is similar to that for impaction and these little patients are not confined to bed over one or two days—the sooner they can be up and about in resuming their normal functions, the better off they are.

If I have recalled to some of your minds, some of the simple conditions which occur in our little kiddies, and have suggested that one should be on the alert for ordinary causes of common complaints,

and have suggested some practical methods which anyone can use in their treatment, then—this little discussion will not have been in vain.

I might say in closing that if anyone came to this meeting with the idea of hearing from me about the

recent experiments in the laboratory of Lokenhoff, Snitler and Whiz Bang—or the studies of Duddlehoff or Schopentrip and Biff in the experimental consideration of the ionization of hyperconcentration of the sudo-pathonesis of the loapotrom, they are going to be greatly disappointed and disillusioned.

The Medical Treatment of Gall Bladder Disease

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The title of this paper was chosen with an ulterior motive—that of snaring the attention of those who may still believe there is any such thing as medical treatment for gall bladder disease. The author, who is an internist, for once finds himself in complete agreement with his surgical friends, who now mostly believe that the gall bladder, like the appendix, is their exclusive property.

The analogy between the gall bladder and the appendix is closer than might appear at first thought. Both are what might be termed "blind pouch" organs, connected to the bacteria laden intestine by narrow, easily blocked channels. While the part of the intestine to which the appendix joins is far more heavily infected than the relatively sterile duodenum, the gall bladder can balance this with the readiness with which it can manufacture its own road blocks, gallstones. Moreover, it may not be necessary for infection to gain admission to the gall bladder by swimming up the common duct. Though usually considered sterile, the bile probably contains normally a few bacteria picked up by the portal blood and excreted by the liver. The blood in the general circulation is usually sterile too, but it has now been clearly demonstrated that bacteria, particularly streptococci can occasionally be grown from the blood of normal individuals. This is especially true following tooth extractions and operations about the nose and throat. Finally the appendix and gall bladder are both to some extent "vestigial" organs, or organs that have ceased to have an important function in modern man, which he can very well get along without.

One of the characteristics of a vestigial organ is its lack of resistance to infection. This is especially marked in the appendix, which in man has no known useful function. We know that the gall bladder has the function of concentrating the bile, but in man it is probable that this function is no longer necessary, as is demonstrated by the large number

of people who now exist in perfect health without the organ. It was probably useful in helping to digest the infrequent fat gorges that the distant ancestors of the human race used to indulge in. Modern man in his food habits is almost constantly eating, compared to the infrequent occasions when wild carnivores customarily satiate their hunger. So the gall-bladder as well as the teeth in man are probably on their way to join the appendix as organs no longer necessary to existence.

We need go no farther into the mysterious origins of gall bladder disease and gallstones than to summarize that most credible evidence now points to some combination of infection and stasis. Since we have already pointed out that chance infection is probably very often present, it would appear that the factor of stasis may be of considerable importance. The eating habits of modern man and woman, it seems to the author, have not been sufficiently closely examined in this connection.

Gall bladder disease occurs in both sexes, but is well known to predominate in women, and especially in those who have borne children. Various explanations have been given for this—a higher level of blood lipoids in pregnancy, interference with emptying of the gall bladder by the distended uterus, and so on. But may not the composition of the diet also have some influence here? The most powerful stimulus we know of to the emptying or drainage of the gall bladder is the ingestion of fat. Civilized man has to a large extent replaced fats and oils as a source of energy with carbohydrates and sugars, which furnish no stimulus to contraction of the gall-bladder. Now, how many women do you know who have never tried to reduce? Or how many pregnant women have you told they were getting a little too fat for the optimum size of the baby, or for the avoidance of toxemia? The first consideration in a reducing diet is the prohibition of fat, and this is equally prohibitive of gall bladder drainage.

Consider the rarity of gallstones in the negro, which all of us have often remarked. They have just as high a proportion of females as the whites, and a higher incidence of pregnancy, but they don't get gall bladder disease. Can this have anything to do with their diet? Generally, the diet of the negro is poorer in general quality and especially in vitamins, than the white. Generally, carbohydrates such as rice, grits and bread form a considerable element of their food. But on the other hand, they cook all of their vegetables with a large hunk of fat meat and fry everything possible. This higher proportion of fat in their diet must surely lead to a more frequent and complete emptying of the gall bladder than can be had with the bird-like and fat avoiding subsistence of many of their white brethren.

It seems to the author that if there is any relation of medical management to gall bladder disease, it might well consist in an attempt at prevention by the inclusion of a reasonable amount of fat in the diet and the avoidance of obesity by exercise and carbohydrate reduction rather than diet with the emphasis on the elimination of fat.

Since the gall bladder is a relatively dispensable organ, the dangers of disease do not reside in loss of its function, but in complications, as acute cholecystitis, blockage of the common duct, cholangitis and carcinoma. A study of mortality figures from the recent experience of two large clinics will show this clearly, when compared with a series of 114 cases known to have cholelithiasis and followed from 10 to 25 years.

Lahey Clinic, 1935-1943 (1)

	Cases	Deaths	Percent
Chronic cholecystitis:			
with gallstones	178	0	
without gallstones	23	1	
	201	1	0.5
Acute cholecystitis:	71	5	7.0
Stones in common duct	84	8	9.5

Mayo Clinic, 1942-1944 (2)

	Cases	Deaths	Percent
Chronic cholecystitis:			
with gallstones	2987	17	
without gallstones	250	3	
	3237	20	0.6
Acute cholecystitis	273	6	2.2
Stones in common duct	559	9	1.6

Jaguttis, follow-up of cases of known cholelithiasis from 10 to 25 years (3)

	114	%
Total patients	114	
Carcinoma of gall bladder	5	
Deaths from complications, no operation	13	
Deaths from complications forcing operation	4	
	22	
Total	114	19

In the face of these figures, it is impossible to defend medical treatment of gall bladder disease. Let us examine the usually recommended medical procedures and see what they could possibly accomplish.

Restriction of fat in the diet is supposed to cut down the manufacture of more stones from cholesterol, and to make the patient more comfortable. It may make the patient more comfortable, but the resulting poor emptying of the gall bladder would probably cancel out the low cholesterol intake.

The feeding of bile salts seems an utterly useless procedure. Unless the liver is all but completely destroyed, it can make all the bile necessary, and just furnishing more bile salts is not going to help the diseased gall bladder to concentrate them.

The drainage of the gall-bladder by instillation of magnesium sulfate into the duodenum might conceivably be of some use where no stones are present, but might lead to the lodgement of stones in the common duct in cholelithiasis. The fact that it seems mostly to have gone out of fashion seems to indicate that it was never of much value.

There really is no logical medical treatment of gall bladder disease. Patients who are too poor risks for operation should be advised to eat what experience has shown will not cause them discomfort, given morphine and antispasmodics during acute attacks, and worried along with as best one may: the time to have cured them of their disease is now past. Any physician can call to mind patients who "got by" for many years without surgery and with his own pet treatment. But any surgeon can quote from his mortality figures those who didn't get by and were forced into operation by some complication.

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The Public Health, the Politician, and the Doctor

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(This paper was presented at the Second Annual Conference of Presidents and Other Officers of State Medical Associations, San Francisco, June 30, 1946. It was the outstanding paper of the Conference and warrants careful reading by every physician.)

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I shall not detain you with any exposition of the variety and the importance of the subject which I intend to treat since to do so would serve only to bring into sharp relief the weakness of the treatment. I shall content myself, then, with the statement that I believe Health Insurance to be one of the most vital issues before the American people today and to be of greater importance to us as citizens than as physicians.

One of the greatest difficulties that we encounter when we attempt to debate a subject so controversial as Health Insurance, is the natural tendency of human beings to be dogmatic. We like to think of "good" as an absolute, with its opposite, "bad" as an equally definite and sharply defined entity, failing to notice that between good and bad is a long line of graded states which are neither absolutely good nor absolutely bad. With such not entirely rational thinking, we prevent ourselves from seeing clearly that the most nearly correct solution to any problem will be reached only if we compel ourselves to attempt the evaluation of a long series of alternate probabilities.

The health of the American people is deplorable, cry the proponents of Compulsory Health Insurance. Nonsense, reply their opponents, the public health is so good that little if any improvement could be made. Compulsory Health Insurance will furnish everyone with better medical care, says the reformer. You're wrong, say many people; only the old fee-for-service method can do so. All of these statements are completely false, and truth lies somewhere between them, and, if we wish to find the truth, we must explore the areas that lie between these sharply opposing theories.

I suppose that none of us will dispute the proposition that there is a problem of medical care. We will concede that there are inequities in its distribution; that its costs are unpredictable, and that they often fall with catastrophic effect on individuals and families who are ill prepared to meet them. The distribution of doctors is not ideal, and there are

areas in which it is difficult or, perhaps, even impossible to secure really good medical care. No one could contemplate the vast amount of literature which has appeared in the past twenty years, or recall the earnest attempts which have been made to enact health insurance legislation and remain unconvinced that a problem really does exist.

Once this premise is granted, our problem becomes very much simpler, being only to find the correct answer or, at least, to find the answer which will work best in experience. To the entire problem there are three possible solutions, (1) to continue the administration of medical care as we have administered it in the past; (2) to let government do it (I shall mention some of the various ways in which this may be done) and, (3) to do it ourselves in the American tradition by means of voluntary health insurance. Each of these methods has its advantages and its disadvantages; none is absolutely bad, or absolutely perfect, and we must now, by the evaluation of our series of probable alternates, attempt to discover how much the advantages of any one of them outweigh, or are outweighed by, the disadvantages. When we have done this, we should be in a position to choose that plan which, in the main, will most benefit the public health. Nor should we fail to make sure that the chosen plan will be beneficial to the doctor, since without him, medical care cannot be supplied. That we should make any very serious attempt to benefit the politician seems a little doubtful, his role in the administration of good medical care being somewhat obscure in spite of his eager self-nomination.

I think that we may dispose of our first alternative, maintenance of the status quo, rather summarily. It has served the people well. The entire profession of medicine may point with pride at its record over the years. Proponents of Compulsory Health Insurance to the contrary notwithstanding, our health record has been an admirable one. We are the healthiest people in the world. Life expectancy and longevity have increased steadily; our morbidity and mortality rates decline constantly. The medical profession has given freely of itself to accomplish these miracles and to care for the sick regardless of ability to pay. Those who would have America believe that the poor man who is ill will receive no medical care; that ability to pay is the criterion for health, are either entirely ignorant in the matter, or, for purposes of their own, are uttering malicious nonsense.

Nevertheless, it is likely that we must abandon the

tried and proven methods of the past, and must find some new way to give medical care to the people. As I have indicated, this is not because we have failed. It is because our science is becoming so vast and so complex that costs must necessarily rise steadily if we are to apply it well, increasing the hardships of too many of the sick. We must consider, then, whether government or the medical profession can do the job better; whether we shall have compulsory or voluntary health insurance.

Nowhere is the yawning chasm between illusion and reality more evident than in the proposed system of Compulsory Health Insurance. The naive assumption that its enactment would redistribute physicians, for example, and its profound confidence in the role of preventive medicine are striking examples. Since preventive medicine is a phrase much beloved by the social reformer, who is persuaded that a visit to the panel practitioner will insure one against having cancer of the stomach, let us see what the currently proposed Compulsory Health Insurance Bill provides. Sec. 205 directs that methods of administration shall aid in the prevention of disease, disability and premature death. As Hamlet said, "A consummation devoutly to be wished for," but a typical example of illusion vs. reality in which the illusion is that disease may be prevented by writing such a sentence into a proposed law. The only other reference to preventive medicine is in Sec. 213, which authorizes and directs the Surgeon General to administer grants-in-aid to certain agencies engaging in research. That grants-in-aid do not necessarily advance preventive medicine, or that a very simple law might authorize them without the cumbersome machinery of Compulsory Health Insurance does not seem to have occurred to the authors.

I need not point out to this audience that the social reformer's profound faith in preventive medicine, although touching in its child-like nature, is not very well founded in fact. Nevertheless, in the hope that an intelligent law-maker may some day seek enlightenment, I feel that I should point out the plain fact that preventive medicine simply has not, as yet, attained to the goals wished for. To cite a very few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How is cancer prevented? Why will the availability of a panel practitioner, (who, in any case, will not have time to have her undress) persuade a woman with a lump in her breast to seek advice? (The commonly given reason that she did not see the doctor is that she knew it wasn't cancer because it didn't hurt; never have I encountered such a patient who said she didn't go to the doctor because she couldn't afford it.) How shall we prevent, or even recognize early brain tumors? Shall every one with a headache have ventriculographic or encephalographic studies? Shall we do gastrointestinal x-ray examinations of every one with indigestion? And, if

so, where shall we obtain the skilled personnel? How are bone tumors prevented, and what health examination makes one aware of the pneumonia of next week?

On November 19, 1945, the President of the United States in his message to Congress, pointed out that in every year four or five hundred million work-days are lost because of illness or accident, and that about nine-tenths of this loss is due to illness and accident not covered by workmen's compensation law. But he failed to state how many accidents would be prevented by Compulsory Health Insurance. He says that more than one-half of the disabled workers have already been disabled for six months, that many will continue to be disabled for years, and some for the remainder of their lives. I am not prepared to dispute this statement. I only wonder how it is linked logically with compulsory health insurance. Will health insurance end automobile accidents? Does it have the mysterious faculty of causing union in a compound fracture of the femur which, under our present system, will not unite? Will it repair the severed tracts of the spinal cord, and prevent the organization of the clot in the sub-dural hemorrhage?

It would be both interesting and informative to know what part of the four or five hundred million work-days were lost because of that great enemy of man, the common cold, and to know whether the proponents of national sickness insurance have in mind a means of finally overcoming this disease. If they have, then I must admit that there is some merit in their plan.

Gentlemen, it is not only futile; it is a little wicked to draw unwarranted inferences which seem to brighten the rather dull world of reality; to promise that which cannot be performed; and to arouse false hopes in the unfortunate. The social reformer might well learn at least one lesson from the physician, i.e., not to confuse reality and wishful thinking.

Lack of realism is further shown in the child-like belief that medical care and health are practically synonymous terms. As a matter of fact, medical care is only a part, and by no means the most important part, of the problem of health. Medical care is the care of the sick and injured. Health consists in not being sick or injured, and depends almost entirely upon sanitation, hygiene, safety factors, health education, good nutrition, good housing, adequate clothing, sound working conditions, and the control of patent medicines and the cults, and a government sincerely interested in the public health might turn its attention to some of these problems instead of attacking only a small fraction of the problem and promising miracles.

I have pointed out before that the entire argument for Compulsory Health Insurance is founded on premises which do not bear investigation; that

the urgency has been shown by emotional statements, rather than by documented facts, and that all the evidence available tends to show that the public health will be harmed rather than helped by the enactment of a Compulsory Health Insurance law.

Briefly, the argument for such legislation is that the state of health of the American people is bad; that the reason for this is that a financial barrier is interposed between the sick man and the doctor; that physicians are unevenly distributed and that nothing has ever shown the true and deplorable state of the public health as have the Selective Service figures. As lately as November, 1945, the President of the United States quoted them gravely to the Congress, as though they had some serious and real significance. This is a statement of the case for Compulsory Health Insurance, and with it goes the blithe assumption that these ills, real and imaginary, will be promptly healed by its enactment. Let us examine the premises since, if it can be shown that they are unsound, the argument will fall of its own weight so far as logic goes. I must confess, however, that thus far there has been a remarkably small admixture of logic in the arguments for Compulsory Health Insurance, and that its proponents will, in all likelihood, remain totally unmoved by logical argument.

The health of the American people is *not* bad; on the contrary it is extraordinarily good, and the most casual glance at the morbidity and mortality tables is all that is needed to completely refute any argument to the contrary. This seems a good time to explode one current myth, namely that the one piece of evidence showing our great need for Compulsory Health Insurance lies in the fact that the maternal mortality rate in the United States is materially higher than in Great Britain. In fact it is, and the social reformer points to this as a brilliant example of our backwardness and of the benefits to be derived from Compulsory Health Insurance. Dr. Samuel Johnson once said to Mr. Boswell, "Sir, the trouble with people is not that they are ignorant; it's that they know so many things that aren't so!" In the United States maternal mortality includes deaths from criminal abortion; in Great Britain these deaths are in a separate table. When the figures are adjusted either to exclude such deaths from our tables or to include them in those of Britain, the result is just what you would expect it to be;—our maternal death rate is the lower. Is our constantly increasing expectancy of life a reflection of our lack of good medical care? Is it an accident that medical education has lagged in health insurance countries while we now lead the world?

The reformer loves the phrase, "the financial barrier," by which he means that the patient is supposed to pay the doctor. This barrier was removed for the municipal employees of San Francisco by an ordinance which established a system of compulsory

health insurance for these people. Investigation shows that although they are served by the same doctors, and in the same hospitals as are the uninsured, the incidence of ruptured appendix among the insured was materially higher than among the uninsured. In this instance, at least, the removal of the financial barrier appears not to have had the desired effect. When one reflects that the annual bill for tobacco and cosmetics is more than the annual cost of medical care; that expenditures for alcoholic beverages greatly exceed the bill for medical care; and that vast amounts are expended annually for patent medicines and the services of the cultists, one wonders whether the financial barrier is, after all, so important.

One of the most amazing instances of the conflict between reality and illusion is the assumption that the inequities in the distribution of physicians will be corrected by Compulsory Health Insurance. There seems to be a vague and hopeful feeling that some magic inherent in this so-called social legislation will persuade doctors to leave cities, where medical schools and libraries are located; where hospitals and consultants can be found; and most of all, where a man can have the society of his peers, and go to remote hamlets where none of these things are available and where he can stagnate in intellectual loneliness. Doctors, like other people, locate themselves where they think they are most likely to succeed, and where they will be happiest. Why any one should believe that enactment of a law will change these elementals is something of a mystery, but one which would be solved promptly if a paternal government were to direct physicians in choosing their fields of activity. Any such intent would be vigorously denied, of course, but the government of Great Britain has already assumed this right and has announced that more medical care in rural areas would be provided by paying a somewhat larger capitation fee in such areas and (n.b.) by *forbidding doctors to locate in more populous zones*.

The Selective Service rejection figures of which so much has been made, are contained in the report of Senator Pepper's interim committee. On several occasions I have broken down and analyzed these figures and I shall not bore you with their repetition. Suffice it to say that these figures do not, by any means, indicate a serious defect in our national health, and afford no logical foundation for an argument that Compulsory Health Insurance must be established in America. To date, no one has challenged the breakdown of these figures or the true conclusions to be drawn from them, although Senator Murray's Senate Committee on Education and Labor had an ample opportunity to do so. That they have been cited again and again is a striking example of the use of the newer technique of disposing of an unpleasant truth by simply ignoring it.

Recently there appeared in the "Consumers Guide" a series of questions titled, "Consumers Guide for

Criticizing the Critics of the Murray-Wagner-Dingell Bill." Some of them are of the "Do you still beat your wife" type; if you answer "No," you imply that you have ceased this nefarious practice, while to answer "Yes" is still more damning. Some of them should be answered categorically, and I shall do so now, knowing full well that those who ask the questions have absolutely no wish to hear the answers. Question 18 is one of which the proponents make a great deal: "Are all Doctors opposed to this bill?" Of course not; but if this is to be regarded as favoring enactment of the bill, one had as well ask, "Are all laws good?", and having received an honest negative answer, argue that then there should be no laws. A small minority, a very small minority of physicians favor Compulsory Health Insurance. But the overwhelming majority, perhaps 95% of all physicians, oppose it most bitterly. Question 3 is one that should not have been asked. It is: "How much will it cost you?" One might well reply, "How much indeed?" The Murray-Wagner-Dingell Bill is seventy-eight pages long, but nowhere in it is there a single reference to the cost to the American People, nor an indication of how the necessary funds will be provided. Here is a startling illustration of the role of the politician in the administration of medical care. Had the pending bill contained an appropriation, or levied taxes, it would not have been referred to the Senate Committee on Education and Labor, but to a much less friendly group. Taxed with this, the proponents reply jauntily that such mundane matters can easily be attended to later, and that the important thing is to get the legislation enacted. Of course, if the Congress were to enact the bill, it could not refuse later to set up the necessary financial machinery, and in the meantime, it seems inexpensive. Actually, estimates of the cost vary rather widely. The President has estimated it at about three billions annually. Elizabeth Wilson, an actuary writing in Barron's weekly, thinks that four and one-quarter billions will be nearer the true cost, and further calculates that the costs will rise steadily, and will not level off for fifty years, at which time the total costs of social security will equal one-fourth of the entire annual wages of America. It seems fair to assume that National health insurance will not be free, or even cheap, and vague intimations of its inexpensiveness reflect either ignorance or dishonesty.

Question 4 is a rather naive one: "Can doctors working on a fee basis take care of all the people needing medical care?" Ignoring the fact that one rarely sees people dying or even ill because they couldn't get a doctor, one can give the obvious answer. That answer is—perhaps not, but what legislative magic will enable the same doctors to serve more people under a capitation plan? Number 8 is two questions, and reflects sharply the truth of Dr. Johnson's aphorism. Part one is, "Is state control bad?", to which one may flatly and unhesitatingly answer, "Yes." Part two continues, "and medical

association good for sick folks?" I assume that the word "control" is inadvertently omitted, and that Medical Association control is what is meant. Only the reformer and the politician know what is meant by, "Medical Association control." Those of us who have belonged to medical associations for most of our lives can only wonder; and sometimes wish that our associations had some of this fabulous control. Apparently we have erred in believing that the practice of medicine is controlled by each of the several states through the medium of a State Board, commonly appointed by a governor. Therefore, it is a little difficult to say whether "Medical Association control" is good or bad, since none of us has ever had an opportunity to observe it in action. Question 24 speaks of Co-operative hospitals and inquires why the medical association opposes them. I presume that the reference is to that terrible ogre, the American Medical Association, and I wonder what sort of opposition it has been offering. I thought that the Association, through its Council on Medical Education and Hospitals, encouraged hospitals, and rewarded those which raised their standards sufficiently with its approval, and that all of this was for the improvement of medical care and to the benefit of the public health. Well, I suppose that I've been deceived, and the old ogre goes about growling at hospitals that try to care for the poor, and to insure the sick a reasonably high level of medical care. Be sure, though, that when these chains have been broken, and national health insurance is a fact accomplished, we will have no more of this nonsense, and the natural and sensible criterion of "how many votes can be delivered" will replace all this silliness about how good is the medical care to be administered to the sick.

There are two ways in which the government can control the administration of medical care. One is by Compulsory Health Insurance, and the other is by supplying medical care through physicians who are servants of the State. The President, in his message to the Congress, called this socialized medicine, and said that the American people want no such system. I think that that is true, but I doubt that they want the proposed system, and I am sure that they would not want it if its implications were fully understood. Let me point out two things to you: First, the President's repudiation of what he called socialized medicine loses some of its fire when one reads the language of S. 1606. Paragraph k of Section 203 authorizes the appointment in the Public Health Service of such personnel and in such grades as may be necessary, and directs that such personnel and commissioned officers of the regular or reserve corps of the Public Health Service may be assigned to duty as the Surgeon General may find it necessary, *without regard to limitations otherwise specified in the Public Health Service Act*. Why? For what purpose? Could these be the doctors to be employed by government, abhorred of the President? Before we attempt an answer, let us consider a statement of

the International Labor Office: "The fact is that once a whole employed population . . . is brought within the scope of compulsory health insurance, the great majority of doctors, dentists, nurses and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care given by the public assistance authorities on the other. The next step to a single national medical service is a short one." This statement seems to me to cast some light on the language of Sec. 203, and the light becomes very bright as one reads the daily paper and realizes that the short step is being taken in England, where the single National Medical Service is now coming into being.

But if we had national sickness insurance, would it really improve the public health? One could devote considerable time to proving that it would not; that, on the contrary, it would inevitably lower our health standards. One could present comparative tables of morbidity and mortality in insurance countries and those without insurance, and could weigh these according to living standards, to available transportation, to standards of medical education, and so-on indefinitely. But all this is unnecessary. One of the ablest of the proponents of health insurance has answered our question already, and in a most conclusive fashion. Dr. Nathan Sinai, co-author of Simons' and Sinai's work, "The Way of Health Insurance," says in that book: "Contrary to all predictions, the most startling thing about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance." This seems to me a rather sound argument against Compulsory Health Insurance, although doubtless Dr. Sinai did not intend it to be. To clinch the matter he adds, "It seems to be a safe conclusion that insurance has certainly *not* reduced the amount of sickness." This puzzles me a little, since I had naively assumed that the intent *was* to reduce the amount of sickness and to improve the public health. I believe that this evidence alone warrants the flat statement that Compulsory Health Insurance will not improve the public health.

Having thus disposed somewhat summarily of Compulsory Health Insurance, and agreed that our old and proven fee-for-service system of giving medical care is no longer capable of adaptation to our modern social-economic milieu, we have remaining to us the consideration of voluntary health insurance. It is my sincere belief that, given reasonable time, and freedom from governmental regulation and bureaucratic red-tape, voluntary health insurance can and will give more medical care, and much better medical care to more people than can ever be cared for under a regimented socialistic plan of national health insurance. It is quite true that thus far a not too impressive total of people are covered under such plans; that the coverage offered is not ideal and that, in general, voluntary plans cannot yet claim to have answered the problem. It is equally true that the American republic evolved by trial and error; that its early history portended failure and disaster, and that evolution is a much slower and less dramatic process than revolution, but that the evolutionary product is likely to be a better and sounder one than that which results from revolution. In a field in which there is only a meager amount of actuarial knowledge and a minimum of experience, haste must be made slowly, and this is no less true of compulsory than of voluntary health insurance. In a relatively short time, voluntary health plans have made astounding progress, and these plans are in their merest infancy. They offer good medical care, at prices that people can afford, and they give this care without bureaucracy or regimentation, in keeping with our American traditions and without offense to our American dignity. If seventy-one million Americans can be persuaded, without any element of compulsion, to buy life insurance, what reason is there to believe that they will not buy health insurance? And if they will not, will not this be convincing evidence that they do not wish to provide themselves, or to be provided with, prepaid medical care? And are we not still free men, and cannot we decide these things for ourselves, without paternal compulsion from an all-wise government?

Gentlemen: On the answer to these questions hangs not only the future of Medicine, but the future of America, the America in which we were reared. Liberty and its concomitant obligation to care for one's self is being weighed against alleged security and the inevitable loss of our freedom. Which we shall have is in our hands, and in the hands of our fellow Americans. Destiny awaits just around the corner, but destiny may still be altered by our will.

The Journal of the South Carolina Medical Association

EDITOR: Julian P. Price

Florence, S. C.

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Office of Publication: (In care of the Editor) -----
Subscription Price -----

Florence, S. C.
\$3.00 per Year

OCTOBER, 1946

OUR 1947 MEETING

The 1947 meeting of our Association will be held at Myrtle Beach, May 6, 7, 8. Tuesday, May 6, will be devoted to the meeting of the House of Delegates. Wednesday and Thursday, May 7 and 8, will be given to the scientific sessions. The annual banquet will be held on Wednesday evening.

The Ocean Forest Hotel will be the official headquarters.

CONGRATULATIONS

The Journal wishes to join with his host of friends in congratulating Dr. James McLeod on the splendid record he made in the recent campaign for Governor. "Starting from scratch" in the early part of the year, with no former political experience, he amassed a sufficient number of votes to reach the secondary primary where he gave the Governor-elect, Strom Thurmond, a hard fight to the finish.

It is not only with regard to the number of votes which he secured, however, that we wish to commend Dr. McLeod, but with reference to the manner in which he conducted his campaign. At the outset, Dr. McLeod presented his platform in printed form so that all would know the principles to which he adhered and the plans which he had formulated for the future. His campaign was based upon the high level of a presentation and explanation of his platform. At no time did he descend to a discussion of personalities or to a personal fight against any of his opponents. He probably made mistakes in the field of politics, but he proved his worth as a statesman.

The physicians of South Carolina and the members of our Association, of which Dr. McLeod is President, can well afford to be proud of their colleague. His activities in recent months have reflected credit upon himself and upon his profession.

THE HOSPITAL SURVEY

Early this year, the General Assembly instructed the State Research, Planning and Development Board to make a hospital survey of the state. Provision was also made for an Advisory Council to work with the Board, such Council to be composed of eleven members.

We are glad to report that the Council has met with the Board and that the Survey is now under way. Dr. Ben Wyman, State Health officer, is Chairman of the Council. Representing our Association are Drs. Jack Parker of Greenville, Kenneth Lynch of Charleston, and Julian Price of Florence.

The survey is being directed by Mr. W. N. Walters, who is working under the supervision of Mr. R. M. Cooper, Director of the Research, Planning and Development Board.

Statistics have been gathered with regard to the population of the state (by age, sex, and race; by counties; according to cities, towns, rural areas; etc.), the economic status of the population, the health status of the people, the number of active physicians in the state, the number of specialists, the number of dentists and osteopaths and of medical service personnel (laboratory technicians, etc.). All of this will give a necessary factual background to subsequent studies.

Regional meetings of the hospital superintendents and other personnel have been held in Greenville, Columbia, Florence and Charleston. At these meetings, full explanation was given of the questionnaires which each hospital is asked to complete. Forty hospitals were represented at these meetings.

As the results come in from these questionnaires and others, results will be tabulated. Once all the data is at hand, the final report will be submitted to the Board and to the Council for consideration. From these considerations will come specific recommendations regarding a definite program for hospital expansion in this state.

It is obvious that the making of this survey will necessitate both time and work. Physicians con-

nected with hospitals now in existence or physicians who are concerned with planning for new hospitals are requested to place their knowledge and suggestions at the disposal of the Board.

We feel that we are fortunate in having Mr. W. N. Walters as the Director of the Hospital Survey.

Mr. Walters was Superintendent of the Lewis Gale Hospital, Roanoke, Va., for sixteen years. The hospital had from 150 to 175 beds. For two years he was Superintendent of the Erlanger Hospital, Chattanooga, Tenn., which had 500 beds. Simultaneously, he was Superintendent of the Children's Hospital, with 75 beds.

He has been President of the Virginia Hospital Association for two years, and a delegate to the American Hospital Association for the same period of time. He is now President of the Tennessee Hospital Association and a member of the State Planning Board of the State of Tennessee.

Before coming to Columbia to begin work on the South Carolina Health Facilities Survey on July 15, 1946, Mr. Walters directed the Survey of Hospital Facilities for the State of Tennessee.

He is now awaiting the completion of the East Tennessee Baptist Hospital, which will have 367 beds, and where he will be Superintendent.

Mr. and Mrs. Walters are making their home in Columbia at present.

OUR MEMBERSHIP

For the first time in the history of our Association, our membership has passed the one thousand mark.

One gratifying feature has been the desire of the younger men who are locating in the state to join the Association. This coupled with the fact that our older members have been more faithful than usual in paying their annual dues has caused our increase in number.

THE DIRECTORY

Each year for the past four years we have published a Directory of the members of the Association. This year a new feature is added in that the Directory will be printed in a little booklet separate from the Journal. We feel that in this way it will prove to be far more serviceable to our members. As usual, the names will be listed alphabetically and also geographically. Every effort has been made to make the Directory as accurate as possible. If any names are omitted or if any initials are wrong, members are asked to make necessary allowances for human error, and to inform the Secretary of the mistakes.

RECOGNITION

Our delegate to the American Medical Association, Dr. Hugh Smith, has been appointed as a member of a special committee to inquire into the general situation of the military rank accorded doctors of medicine during World War II. We feel that this is a distinct honor to Dr. Smith and to the Association.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

LABOR'S NEW APPROACH

An interesting development and one termed as of national significance, is the recent agreement entered into between the Federal Government and the United Mine Workers under the leadership of John L. Lewis. It represents a departure from the traditional demands of labor for wage increase, and represents a humanitarian approach which may have great appeal. The effect of the agreement is to place health and medical services for the workers under union control. What has happened and is represented by the agreement in this industry, can be expected to extend to others if the trend continues, as now seems very likely.

A recent news bulletin issued by the Council on Medical Service and Public Relations, AMA, calls attention to this development, points out the following events in connection therewith, and emphasizes the importance of the situation both from a medical and political standpoint.

"I. Money collected in the first six weeks will net three and one-half million dollars for the miners' welfare and retirement fund. That's from just *one* of the two funds, separate in nature and source, that are set-up under the coal agreement. These two funds are: a. The welfare and retirement fund, created by a five cent per ton impost on every ton of coal produced, is to be administered by three trustees, one appointed by the Coal Administrator, one by the union, and one to be agreed upon by both the Coal Administrator and John Lewis. b. The medical and hospital fund to be administered entirely by three trustees appointed by the president of the Mine Workers Union and to be built up by check off from miners' pay.

"Heretofore most of the medical service in the bituminous coal industry has been rendered by physicians under direct contract with the coal operators. Hereafter arrangements for such services will be in the hands of the union.

"2. The health and medical service survey of the bituminous coal mine areas of the Navy under the direction of Vice Admiral Ben Moreell, Coal Administrator, and conducted by Rear Admiral Joel T. Boone, (MC), U.S.N., Director of Medical Survey, is under way. The document which results will be of great importance to the entire practice of medicine.

This is a fact finding survey conducted by five teams of Navy Men, each directed by a Navy medical officer. These surveys being conducted under the direction of physicians will be in sufficient detail to get the facts in regard to hospitalization, medical service, housing, recreational facilities, etc., throughout the bituminous industry which includes more than two-thirds of the states.

The definite date for the completion of the survey is not yet determined but Admiral Boone hopes that it may be finished before October. It is understood that the Coal Administrator will await the outcome of the survey before making his recommendations to the Secretary of the Interior and to the President of the United States.

"3. The formation of the Association of Mine Physicians completed recently at Williamson, West Virginia, brings to the forefront many problems and conditions under which medical practice has been conducted in the soft coal areas. At the present this organization is made up largely of those doctors doing work in the West Virginia, Kentucky, Tennessee, Pennsylvania, Virginia, Alabama, areas. Principal direction in the movement has been provided by George W. Easley, M. D., Williamson, and E. O. Rogers, M. D., Bluefield, West Virginia.

"4. Resolutions presented by Kentucky and Michigan and passed by the House of Delegates at the San Francisco session, call for an active interest by the American Medical Association under the direction of the Council on Medical Service in conjunction with the Council on Industrial Health."

PUBLIC HEALTH, POLITICS AND MEDICINE

One of the clearest statements we have seen on the subject of the need for health insurance and the form it should take, was that of Dr. Lowell S. Goin before the second Annual Conference of Presidents of State Medical Societies in San Francisco. Dr. Goin is a prominent Californian and on June 30, 1946, retired as President of the American College of Radiology. He believes that one of the great difficulties that we encounter in attempting to debate such a subject "is the natural tendency of human beings to be dogmatic. We like to think of 'good' as an absolute, with its opposite 'bad' as an equally definite and sharply defined entity," failing to recognize that the proper course lies somewhere between the two extremes advocated by their ardent proponents. Dr. Goin is willing to concede that there

is a problem of medical care, that there are inequities in its distribution and its costs, and where the latter will fall unpredictable; also that the distribution of doctors is not ideal, and that there are areas in which it may even be impossible to secure really good medical care. The activity and the vast amount of literature which has appeared in the past 20 years in the effort to enact health insurance legislation, are sufficient, he thinks, to establish reasonably well the fact that a problem does exist. He continues,

"Once this premise is granted, our problem becomes very much simpler, being only to find the correct answer or, at least, to find the answer which will work best in experience. To the entire problem, these are three possible solutions, (1) to continue the administration of medical care as we have administered it in the past; (2) to let government do it (I shall mention some of the various ways in which this may be done) and, (3) to do it ourselves in the American tradition by means of voluntary health insurance. Each of these methods has its advantages and its disadvantages; none is absolutely bad, or absolutely perfect, and we must now, by the evaluation of our series of probable alternates, attempt to discover how much the advantages of any one of them outweigh, or are outweighed by, the disadvantages. When we have done this, we should be in a position to choose that plan which, in the main, will most benefit the public health. Nor should we fail to make sure that the chosen plan will be beneficial to the doctor, since without him, medical care cannot be supplied. That we should make any very serious attempt to benefit the politician seems a little doubtful, his role in the administration of good medical care being somewhat obscure in spite of his eager self-nomination.

"I think that we may dispose of our first alternative, maintenance of the status quo, rather summarily. It has served the people well. The entire profession of medicine may point with pride at its record over the years. Proponents of Compulsory Health Insurance to the contrary notwithstanding, our health record has been an admirable one. We *are* the healthiest people in the world. Life expectancy and longevity have increased steadily; our morbidity and mortality rates decline constantly. The medical profession has given freely of itself to accomplish these miracles and to care for the sick regardless of ability to pay. Those who would have America believe that the poor man who is ill will receive no medical care; that ability to pay is the criterion for health, are either entirely ignorant in the matter, or, for purposes of their own, are uttering malicious nonsense.

"Nevertheless, it is likely that we must abandon the tried and proven methods of the past, and must find some new way to give medical care to the people. As I have indicated, this is not because we have failed. It is because our science is becom-

ing so vast and so complex that costs must necessarily rise steadily if we are to apply it well, increasing the hardships of too many of the sick. We must consider, then, whether government or the medical profession can do the job better; whether we shall have compulsory or voluntary health insurance."

Dr. Goin then takes up the principal fallacy in the argument of the proponents of compulsory health insurance, i.e., that the enactment of such legislation would solve the problems which exist. Referring to Section 205 of the Wagner-Murray-Dingell Bill directing that methods of administration shall aid in the prevention of diseases, disability and premature death, he agrees, in the words of Hamlet, that this is "A consummation devoutly to be wished for," but points out the implied assumption as a typical example of "illusion against reality," the illusion being that disease and premature death might be prevented by the simple enactment of the proposed law.

Absence of logic in the argument of the reformers is indicated further by Dr. Goin. "On November 19, 1945, the President of the United States in his message to Congress, pointed out that in every year four or five hundred million work-days are lost because of illness or accident, not covered by workmen's compensation law. But he failed to state how many accidents would be prevented by Compulsory Health Insurance. He says that more than one-half of the disabled workers have already been disabled for six months, that many will continue to be disabled for years, and some for the remainder of their lives. I am not prepared to dispute this statement. I only wonder how it is linked logically with compulsory health insurance. Will health insurance end automobile accidents? Does it have the mysterious faculty of causing union in a compound fracture of the femur which, under our present system, will not unite? Will it repair the severed tracts of the spinal cord, and prevent the organization of the clot in the sub-dural hemorrhage?

"It would be both interesting and informative to know what part of the four or five hundred million work-days were lost because of that great enemy of man, the common cold, and to know whether the proponents of national sickness insurance have in mind a means of finally overcoming this disease. If they have, then I must admit that there is some merit in their plan.

"Gentlemen, it is not only futile; it is a little wicked to draw unwarranted inferences which seem to brighten the rather dull world of reality; to promise that which cannot be performed; and to arouse false hopes in the unfortunate. The social reformer might well learn at least one lesson from the physician, i.e., not to confuse reality and wishful thinking."

According to Dr. Goin, "the entire argument for Compulsory Health Insurance is founded on premises

which do not bear investigation; . . . the urgency has been shown by emotional statements, rather than by documented facts, and . . . all the evidence available tends to show that the public health will be harmed rather than helped by the enactment of a Compulsory Health Insurance law."

He says that the points in the argument for such legislation are based upon the false premise that the health of the American people is bad, whereas he contends that it is, on the contrary, extraordinarily good. The balance of the argument of the reformers is equally unsound, being to the effect that the reason for the bad health is that a financial barrier is imposed between the sick person and the doctor, that physicians are unevenly distributed, and that the deplorable state of the public health has been glaringly proved by the selective service figures. "With it all," says the author, "goes the blithe assumption that these ills, real and imaginary, will be promptly healed," by enactment of the law.

Pointing out two ways in which the government can control the administration of medical care, Dr. Goin continues. "One is by Compulsory Health Insurance, and the other is by supplying medical care through physicians who are servants of the state. The President, in his message to the Congress, called this socialized medicine, and said that the American people want no such system. I think that that is true, but I doubt that they want the proposed system, and I am sure that they would not want it if its implications were fully understood. Let me point out two things to you: First, the President's repudiation of what he called socialized medicine loses some of its fire when one reads the language of S. 1606. Paragraph k of Section 203 authorizes the appointment in the Public Health Service of such personnel and in such grades as may be necessary, and directs that such personnel and commissioned officers of the regular or reserve corps of the Public Health Service may be assigned to duty as the Surgeon General may find it necessary, *without regard to limitations otherwise specified* IN THE Public Health Service Act. Why? For what purpose? Could these be the doctors to be employed by the government, abhorred of the President? Before we attempt an answer, let us consider a statement of the International Labor Office: 'The fact is that once a whole employed population . . . is brought within the scope of compulsory health insurance, the great majority of doctors, dentists, nurses and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care given by the public assistance authorities on the other. The next step to a single national medical service is a short one.' This statement seems to me to cast some light on the language of Sec. 203, and the light becomes very bright as one reads the daily paper and realizes that the short step is being taken

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**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154.
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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in England, where the single National Medical Service is now coming into being."

The question is asked, if we had national sickness insurance, would it really improve the public health? We are not quite agreed with Dr. Goin's theme that the purpose of the proposed legislation is simply to "improve the public health." In this connection, he refers to a statement by Dr. Nathan Sinai in the book "The Way of Health Insurance" that "It seems to be a safe conclusion that insurance has certainly *not* reduced the amount of sickness." To give the devil his due, we do not believe that the authors and advocates of the proposed legislation would confine their claim for its effects to the matter of the supposed improvement of public health. They contend equally and, as we have understood, even more strongly, that the great need is for increased and improved medical care to those who *are* sick, that improvement of the public health would indirectly result through shortening periods of illness and the decrease of their number through improved medical care. Dr. Goin is probably right in stating that compulsory health insurance will not improve the public health. He might have continued with even more certainty that Compulsory Health Insurance would not improve the quality of medical care, and on the contrary, that it would tend to degrade it.

In conclusion, Dr. Goin briefly states the case for voluntary health insurance. He says, "It is my sincere belief that, given reasonable time, and freedom from governmental regulation and bureaucratic red-tape, voluntary health insurance can and will give more medical care, and much better medical care to more people than can ever be cared for under a regimented socialistic plan of national health insurance. It is quite true that thus far a not too impressive total of people are covered under such plans; that the coverage offered is not ideal and, that in general, voluntary plans cannot yet claim to have answered the problem. It is equally true that the American republic evolved by trial and error: that its early history portended failure and disaster, and that evolution is a much slower and less dramatic process than revolution, but that the evolutionary product is likely to be a better and sounder one than that which results from revolution. In a field in which there is only a meager amount of actuarial knowledge and a minimum of experience, haste must be made slowly, and this is no less true of compulsory than of voluntary health insurance. In a relatively short time, voluntary health plans have made astounding progress, and these plans are in their merest infancy. They offer good medical care, at prices that people can afford, and they give this care without bureaucracy or regimentation, in keeping with our American traditions and without offense to our American dignity. If seventy-one million Americans can be persuaded, without any element of compulsion, to buy life insurance, what reason is there to believe that they will not buy health insurance? And if they

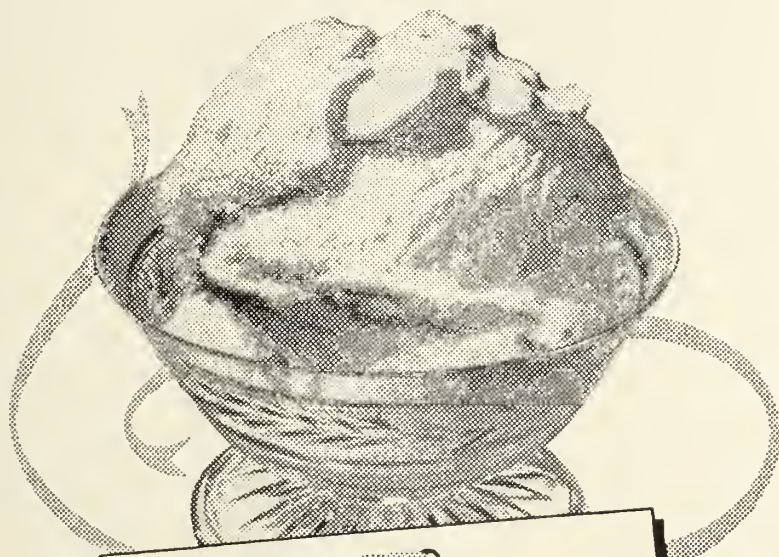
will not, will not this be convincing evidence that they do not wish to provide themselves, or to be provided with, prepaid medical care? And are we not still free men, and cannot we decide these things for ourselves, without paternal compulsion from an all-wise government?"

The writer's final statement is, in our opinion, a fitting climax to a splendid treatment of the subject. It should focus attention on the opportunity afforded members of the medical profession to do a real service to their country. In view of their knowledge of all that is entailed in proper medical care, the physician-patient relationship, and the personal element involved in the practice of medicine, the doctors are faced with the duty not simply to their profession, but to the nation as citizens, to continue the effort to throw the full light of publicity and knowledge on the plans and proposals that are being made. As Dr. Goin says in this splendid concluding statement, "On the answer to these questions hangs not only the future of Medicine, but the future of America, the America in which we were reared. Liberty and its concomitant obligation to care for one's self is being weighed against alleged security and the inevitable loss of our freedom. Which we shall have is in our hands, and in the hands of our fellow Americans. Destiny awaits just around the corner, but destiny may still be altered by our will."

ST. LOUIS CONFERENCE

A conference arranged by the National Physicians' Committee and attended by representatives from every state in the union except one, was held in St. Louis on September 3rd and 4th. The meeting, expenses of which were borne by the National Physicians' Committee, was similar in form and purpose to that held in January. With one exception, all sessions of the conference were held in the Coronado Hotel, conference headquarters. Dr. J. B. Latimer of Anderson, and your Director attended the meeting as representatives of the South Carolina Medical Association.

The sessions of the first day were devoted to reports of developments in Washington, specifically during the hearings on S. 1606, before the Senate Committee on Education and Labor. Mr. Arthur Conrad, who represents the National Physicians Committee in Washington, gave an interesting account of selected incidents involving prominent public figures who testified before the committee. Among the incidents to which he gave special attention was the verbal tilt between Mr. Ickes and Senator Olin D. Johnston, when the South Carolina Senator took the former Secretary of the Interior to task on certain of his remarks regarding the relationship of the Medical profession and the Veterans. Mr. Ickes, it may be recalled, testified as Executive Chairman of the Independent Citizens Committee of the Arts,



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Sciences and Professions, but admitted on examination by Senator Donnel, that he had never read the bill under consideration.

The greater part of the afternoon session on September 3rd was given over to brief statements by a number of doctors who had appeared before the Committee. The experiences of most of these gentlemen were similar. Generally, they reported cooperation and courteous assistance from the senators or representatives from their respective states, on their visits to Washington. The suggestion most frequently voiced by the speakers, to any others who might feel inclined from time to time, or who might be selected by their Societies, to express themselves before a Senatorial Committee, was to arrive in Washington a day or two previous to the date on which one is scheduled to appear, in order to acclimate himself, so to speak, to the legislative atmosphere which prevails.

On Wednesday, future prospects and plans of action were discussed. It was apparently the unanimous opinion that a new bill may be confidently expected shortly after the new Congress convenes.

On Tuesday evening, the delegates of the conference were the guests of the St. Louis Chamber of Commerce at a banquet at the Jefferson Hotel. Dr. Morris Fishbein was the speaker of the occasion, and entertained his hearers with a most interesting and informative address. The conference received on the following day, communication from the Chamber of Commerce, expressing its pleasure in hearing Dr. Fishbein, and its appreciation of having received much information regarding legislative developments which, they said, had been brought to their attention for the first time.

The meeting was climaxed by the address of Dr. Harrison Shoulders, President of the American Medical Association, at luncheon on Wednesday. Dr. Shoulders referred to his recent papers on the Ideal of Medicine, and the Soul of Medicine, and then discussed the necessity of including in our consideration the third element, for successful and progressive medical service—the Economics of Medicine. He quoted interesting figures to show the fallacy of the argument that many people are being deprived of medical care simply because of their inability to pay.

After listening to the reports of the officials in charge of the conduct and business operation of the National Physicians Committee, and noting the enthusiasm and reaction of the members of the conference from all parts of the United States, it was our conclusion that this organization is doing a commendable work for the medical profession in attempting to keep its members informed on current developments in Washington, and by its efforts through perfectly legitimate and proper means, to bring to

the attention of the lawmakers in Congress the real implications of the current efforts toward social reform.

THE FARMER AND COMPULSORY HEALTH INSURANCE

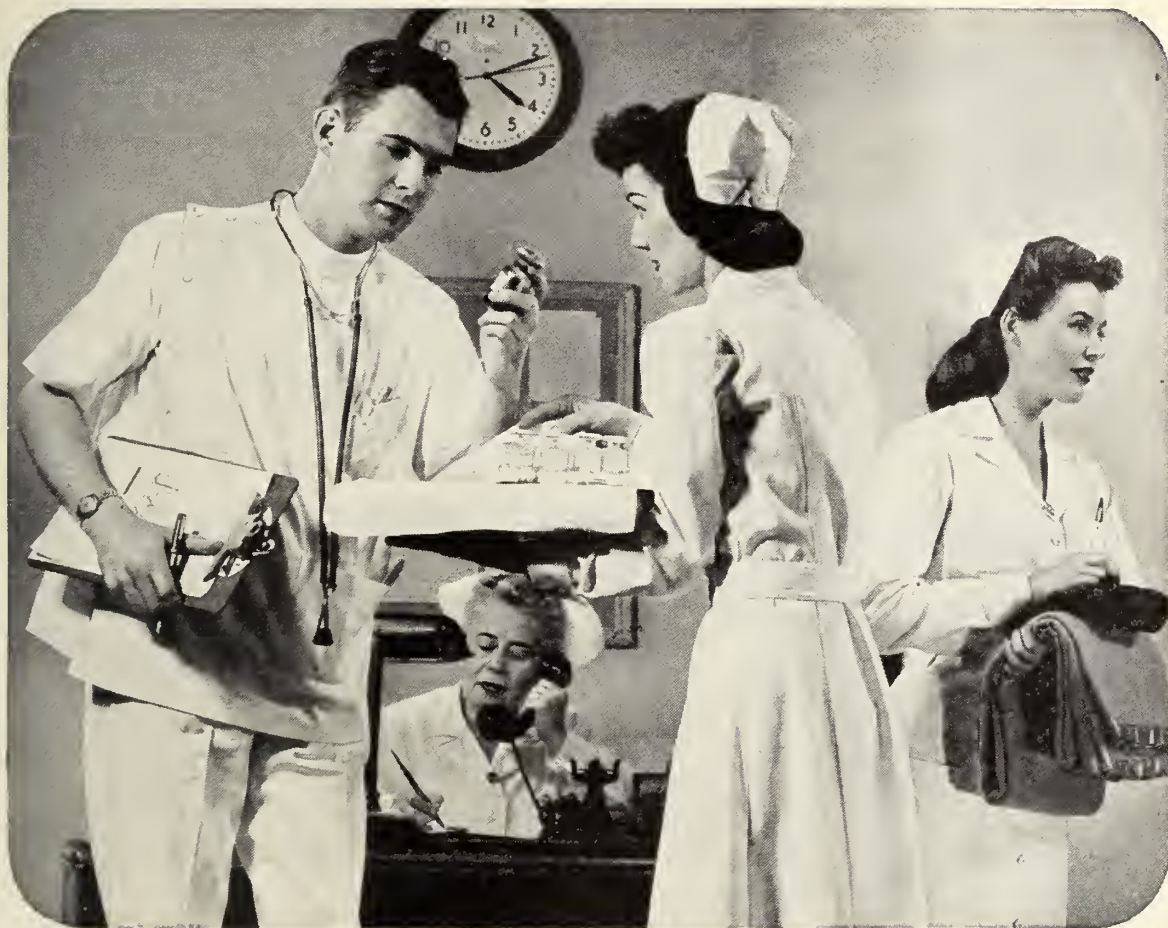
The facts and information reported in the following article which appeared originally in the *Country Gentleman*, May, 1946, and with its permission was reprinted by the Insurance Economics Society of America, will be of considerable interest to the physicians of South Carolina, a predominantly agricultural state. Furthermore, it may enable the doctors to answer more adequately some of the inquiries of their farmer friends and patients, or to voluntarily inform them if the occasion arises, as to some of the results that would have been accomplished by the Wagner-Murray-Dingell Bill of 1945. The issue is by no means a dead one, and the information will be pertinent in reference to other proposed legislation.

"Extending social security to farmers is being considered by Congress, and one plan is offered in the Wagner-Murray-Dingell bill. Much has been said about the benefits to farm people and hardly anything about the cost, cash and otherwise. In a research study, recently published in *Social Forces*, some light is thrown on this part of the proposition.

"The author of this study, Prof. Earl E. Muntz, of New York University, assumes that the Wagner-Murray-Dingell bill is enacted. He uses it to figure the cost of such a system to farmers. The proposed 5 per cent tax on approximately 6,000,000 farmers rating as self-employed persons would yield, on a prewar basis, a little over \$300,000,000 a year. A tax of 4 per cent of the value of services rendered by some 640,000 farm-family workers would yield about \$30,000,000 annually. Hired farm workers would also be taxed to the extent of about \$80,000,000.

"Using 1940 as a basis, the total cost of the Wagner-Murray-Dingell plan to American farmers would be \$420,000,000. In a more prosperous year, such as 1943, Professor Muntz estimates the amount might rise to \$565,000,000. Some idea of the magnitude of the tax outlay may be had by comparing it with farm real-estate taxes, which in 1940 amounted to about \$400,000,000.

"Just how social-security taxes would be collected from farmers has not been stated, but presumably they would be collected by the farmers themselves. Anyone can figure out the cost for himself. A farmer with an income of \$2000 per year would pay \$100, representing the personal tax of 5 per cent on the value of his services. There is also a pay-roll tax, and if he has a hired man he will pay 4 per cent and the employee 4 per cent on the latter's wages. Whether this would include such usual items as



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housing and food is yet undetermined.

"In return, there are offered an array of benefits—old age, retirement and survivors' payments; an expansion of hospital and medical facilities to provide a system of medical and hospitalization insurance, under which practically every employee or self-employed person, such as a farmer, earning up to \$3,000 a year would be eligible along with his wife and children; temporary and permanent disability benefits; and the unemployment insurance, which would be of little interest to most farmers. The total value of all possible benefits to farm people would probably exceed the amount paid in by

farmers. The Government would have to pay the balance from other sources, and what conditions it would impose along with this gratuity can only be guessed.

"How rural people feel about such a sweeping social-security system has never been learned. Farm organization leaders generally would prefer a less ambitious program, limited perhaps to old age and survivors' insurance. Certainly it seems that such a vast and complicated affair calls for more study before any action is taken."

(Continued on p. 294)

PUBLIC HEALTH NEWS

DR. CHARLES I. GOODWIN NEW DIRECTOR CALHOUN AND ORANGEBURG COUNTY HEALTH DEPARTMENTS

Dr. Charles I. Goodwin of Holly Hill was appointed to succeed the late Dr. Grover C. Bolin as Director of the Orangeburg and Calhoun County Health Departments September 1, it has been announced by Dr. H. Grady Callison, Director of the State Board of Health's Division of Local Health Services.

Dr. Goodwin is a native South Carolinian, having been born in Walterboro. He received his degree in medicine from the Medical College of the State of South Carolina in 1911. He served two years in the Medical Officers Reserve Corps in World War I. Since his discharge in May, 1919, he has been engaged in the practice of medicine in Holly Hill. Dr. Goodwin is married and has one child, a daughter, in college.

SOUTH CAROLINA FIRST STATE TO HAVE A STATE HEALTH OFFICER—APPOINTED IN 1712 BY GENERAL ASSEMBLY

The great lawgiver, Moses, is conceded by health authorities to have been the world's first sanitarian, but a South Carolinian has the distinction of being the first State Health Officer, according to Dr. Harry S. Mustard, Director of Columbia University's School of Public Health.

In his latest book, *Government in Public Health*, Dr. Mustard says that the first State Health Officer of record was Gilbert Guttery, who was appointed in 1712 by a special Act of the General Assembly of South Carolina.

Under the provisions of the Act, the duty of the Health Officer was to "inquire into the state of health of all persons who might come into the province

aboard any ship or vessel. He was to board vessels, study the records of the ship and the health of the passengers and, when indicated, send persons to a designated pesthouse, and otherwise to take such measures as he deemed necessary. Various penalties were imposed on those who might violate the provisions of the Act. Further, he was required to change his clothes and cleanse himself before returning ashore should he find sickness on any ship inspected. The sicknesses specified were 'Plague, Smal Pox, Spotted Feavour, Siam distemper, Guinea feavour, or any other Malignant Contagious Disease.'"

The Act of 1712 was repealed in 1721. In 1908, however, the General Assembly, again realizing the need for a State Health Officer, passed another Act creating the office. This Act in part says "The State Health Officer shall be the secretary and executive officer of the State Board of Health, and shall have the power to administer oaths and take depositions in the line of duties; and when directed by the Executive Committee of the State Board of Health, or by the Chairman, when the Board is not in session, he shall investigate the reported causes of communicable or epidemic diseases, and shall enforce or prescribe such preventive measures as may be needed to suppress or prevent the spread of said diseases, by proper quarantine or other measures of prevention, as may be necessary to protect the citizens of the State. All sheriffs or constables in the several counties of this State, and police officers and health officers of cities and towns, shall aid and assist the State Health Officer, to enforce and carry out any and all restrictive measures and quarantine regulations that may be prescribed."

The first State Health Officer appointed under the 1908 Act was Dr. C. F. Williams. In 1911 he resigned and was succeeded by Dr. James A. Hayne, who served continuously for 33 years before resigning in 1944, when he was succeeded by Dr. Ben F. Wyman.

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Shambaugh, G. E., Jr.: J. Iowa M. Soc. 31:373.

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The first State Board of Health, according to Dr. Mustard, was established in Louisiana in 1855. The South Carolina State Board of Health was created by an Act of the General Assembly on the 23rd day of December, 1878.

NEW RAPID TREATMENT CENTER TO BE LOCATED IN FLORENCE—TO HAVE CAPACITY OF 200 PATIENTS

Dr. C. L. Cuyton, Director of the Division of Venereal Disease Control, has announced that the State Board of Health has been granted a license to use the former Florence Airfield Hospital as a venereal disease rapid treatment center.

Although the hospital had a rated army capacity of only 118 patients, it will be possible, Dr. Guyton said, to increase the capacity to 200 or more patients by converting certain barracks into wards.

Before the hospital can be opened, some of the barracks will have to be remodeled, and since all equipment had been removed, kitchen, mess hall and refrigerating equipment will have to be procured from the Army and installed. It is expected that the equipment will be made available within the next few weeks. In the meantime, the buildings are being cleaned and the utilities placed in operation, and equipment not needed at the present hospital is being transferred to the new facility.

Every effort is being made to have the new hospital in operation by October 1, 1946. However, under the circumstances, there is no assurance that this will be possible. In the meantime, it is planned to continue the operation of the present hospital at a capacity of 50 patients until the Florence hospital is opened. As soon as the opening date can be definitely established, full information regarding it will be sent to all Health Departments.

During the past few weeks there have been several instances in which patients (usually ex-servicemen) have been told to come to the hospital by physicians and Health Departments over the State. These patients could not be accepted by the hospital, and consequently have been put to much inconvenience and unnecessary expense. Dr. Guyton strongly urges that no patients be sent unless definite permission has been given by the Division of Venereal Disease Control.

DR. SHERIFF ELECTED 2ND VICE PRESIDENT AMERICAN MEDICAL WOMEN'S ASSOCIATION

Dr. Hilla Sheriff, Director of the Division of Maternal and Child Health, was elected 2nd Vice-President of the American Medical Women's Association at the annual meeting held in San Francisco, June 28-30.

During the current year, Dr. Sheriff is serving as President of the South Carolina Public Health Association.

STREPTOMYCIN TO BE DISTRIBUTED THROUGH 23 HOSPITALS IN SOUTH CAROLINA

Streptomycin, formerly distributed by a special committee in Boston, Mass., is being made available beginning September 1 to the civilian population through designated depot hospitals. These hospitals will be allotted a monthly supply of streptomycin by the Civilian Production Administration. The State Board of Health has been allotted a small supply for use in State operated hospitals. The supply is still very limited and it is doubtful at present if the demand for the drug can be entirely met. The 23 depot hospitals in South Carolina are: Aiken County Hospital; Anderson County Hospital; Marlboro County Hospital at Bennettsville; Camden Hospital; Roper Hospital and St. Francis Xavier Infirmary at Charleston; Columbia Hospital; Providence Hospital, and S. C. Baptist Hospital at Columbia; Conway Hospital; McLeod Infirmary at Florence; Greenville General Hospital, and St. Francis Hospital at Greenville; Greenwood Hospital; Johnson Memorial Hospital at Hemingway; Kelley Memorial Hospital at Kingstree; Marion Sims Memorial Hospital at Lancaster; Tri-County Hospital at Orangeburg; York County Hospital at Rock Hill; Mary Black Memorial Hospital, and Spartanburg General Hospital at Spartanburg; Toumey Hospital at Sumter; and Charles Es'Dorn Hospital at Walterboro.

DR. CALLISON TO STUDY AT COLUMBIA UNIVERSITY

Dr. Caroline H. Callison, Director of the Greenwood and McCormick County Health Departments, is leaving for New York City September 20 to take a year's course in public health at Columbia University.

While Dr. Callison is away, Dr. M. J. Boggs, Abbeville County Health Officer, will be in charge of the Greenwood and McCormick County Health Departments.

CLOSING DATE MAY 15, 1947

The \$34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A. at Atlantic City June 9-13, 1947.

Art works on other subjects may also be submitted for the regular cups and medals.

For full information, write Dr. F. H. Redewill, Secretary, American Physicians Art Association, Flood Building, San Francisco, Calif., or to the Sponsor, Mead Johnson & Company, Evansville 21, Ind., U.S.A.

NEWS ITEMS

South Carolina physicians will play an important part in the Veterans Administration's program for the care of veterans through civilian physicians. The following appointments have been made for Section 5 (comprising the five states of South Carolina, Georgia, Florida, Alabama, and Tennessee): Dr. M. R. Mobley, of Florence, Section Chief of Audiology; Dr. W. A. Smith, of Charleston, Section Chief of Tuberculosis; Dr. E. F. Parker of Charleston, Section Chief of Chest Surgery; Dr. Gertrude Holmes of Greenville, Section Chief of Female Personnel. Dr. O. B. Mayer has also been appointed as regional consultant in internal medicine.

Dr. and Mrs. John A. Anderson of Woodruff announce the birth of a daughter, Deidre, on August 15, 1946.

Dr. and Mrs. Joe E. Crosland of Greenville are being congratulated upon the birth of a son, their second child.

At the September meeting of the Pee Dee Medical Association Dr. James A. Hayne was the guest speaker. His subject—GERIATRIC MEDICINE.

Dr. Harry C. Tiller has recently located in Georgetown.

Dr. C. I. Goodwin, who has been practicing medicine in Holly Hill for a number of years, has given up his private practice to become health officer of Orangeburg County.

Lt. (j.g.) Hugh Smith, Jr., M.C., has returned to the States following service in Japan.

Dr. C. R. F. Baker has announced that Dr. W. D. Hastings is now associated with him in Sumter. Their practice is limited to general surgery.

Dr. Henry W. Moore has opened offices in Columbia to practice pediatrics. Dr. Moore entered the navy in 1942 and was discharged in 1946. Since his release from the navy he has taken post graduate work at St. Louis Children's Hospital. For the past four months he has served as Executive Secretary of the American Academy of Pediatrics' children's health study in this state.

Dr. Caroline Callison, Public Health Officer in Greenwood and McCormick Counties for the past year, has left for Columbia University, where she will study during the coming year. Dr. M. J. Boggs

will be in charge of the Greenwood and McCormick offices until Dr. Callison's return.

Dr. James Y. Bryson of Laurens, has been released from the Army and returned to the States after serving the past eighteen months in France and Germany.

Dr. C. Eugene Yeargin has opened his offices in Greenville for the practice of pediatrics.

Dr. Basil M. Mixon, Jr., is a new member of our Association. He is practicing in Branchville.

Dr. W. E. Baldwin, a native of Due West, has returned to Walhalla to resume his duties as Director of the Oconee County Health Department. Dr. Baldwin has been in the Army for the past four years, twenty-six months of which he served in the European theater with the surgeon-general's staff.

Dr. John Bell has opened his offices in Greenwood and will specialize in the practice of pediatrics. He was released from the army last March.

The second annual meeting of the Southeastern Allergy Association will be held January 18th and 19th, 1947, at the Atlanta-Biltmore Hotel, Atlanta. Hotel reservations should be made directly with the hotel. Dr. Katherine Baylis MacInnis of Columbia is Secretary-Treasurer of the Association.

At the annual meeting of the American College of Chest Physicians held at San Francisco, June 27-30, Dr. R. Kyle Brown of Greenville, was re-elected Governor of the College for the State of South Carolina.

Dr. Everett B. Poole, who served during the war as a colonel in the medical corps, has resumed his practice in Greenville. His practice will be limited to internal medicine.

Dr. Jesse B. Floyd has been appointed Greenville city health commissioner. He was formerly engaged in the practice of medicine in Great Falls.

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WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. S. Harry Ross, Anderson, S. C.

Publicity Secretary: Mrs. J. R. Young, Anderson, S. C.

Mrs. S. Harry Ross of Anderson, president of the Auxiliary to the South Carolina Medical Society, was the speaker on Monday at the luncheon meeting here of the Auxiliary to the Greenville County Medical Society, of which Mrs. I. S. Barksdale is president, and she was accompanied to the meeting by the state secretary, Mrs. Olin Hentz, also of Anderson.

Mrs. Ross spoke on "Our Opportunities," emphasizing the part which the Auxiliary can play in building the health of the state.

The luncheon committee was composed of Mrs. M. Nachman, Mrs. William H. Lyday, Mrs. Frank Daniels, Mrs. J. N. Holtzelaw, Mrs. DeWitt L. Hooper, and Mrs. J. W. McLean.

A very large attendance marked the meeting and members heard Mrs. Ross with a great deal of interest and pleasure.

The table appointments were most attractive. Late summer garden flowers were used in decoration.

DEATHS

DR. F. M. ROUTH

Dr. F. M. Routh, Columbia physician, died suddenly Tuesday night, September 10, while visiting his wife's relatives in Varnville, Hampton County.

Dr. Routh, who was 61 years old, was a native of Hampton County. He was appointed Director of the Greenwood County Health Department in 1917, thus becoming one of the first County Health Officers in South Carolina. He served two years in World War I, and upon his return to civilian life in 1919, he entered private practice in Columbia. For a while he served as pathologist at Columbia Hospital. In 1927 he was elected to the Executive Committee of the State Board of Health. He was Chairman of the Committee from June 26, 1935 to May 1, 1940, when ill health forced him to resign.

Besides his wife, the former Miss Zoe Peebles of Varnville, Dr. Routh is survived by a son, Foster M. Routh, Jr., who recently entered the army and is now stationed at Fort Bragg, North Carolina.

DR. W. S. ZIMMERMAN

On July 18, 1946 William Simpson Zimmerman passed into the beyond after an active and useful life.

Born at Glenn Springs in 1884, he graduated from the Medical College of South Carolina in Charleston in 1909 and did graduate work in surgery at the Gouverneur Hospital in New York. He was associated later with his uncle, the eminent Dr. Frank Simpson in Pittsburg.

He returned to Spartanburg in 1913 and joined the staff of the Steedley Hospital. He and the late Dr. B. B. Steedley instituted the Chick Springs Sanitarium at a subsequent date, and were actively engaged in surgery at the Wallace Thompson Memorial Hospital in Union for many years. He became an active member of the Spartanburg General Hospital in 1921.

He was a member of the American Medical Association, Tri-State Medical Association, Southern Medical Association, South Carolina Medical Association and the Spartanburg County Medical Society.

Dr. Zimmerman began his surgical career at a time when a large part of surgery in this section was

performed in the patient's home, oftentimes on the kitchen table. He was instrumental in the development of better hospital facilities in the Piedmont, and the splendid Spartanburg General Hospital is in great measure due to his influence and efforts.

Possessed of a modest and unassuming disposition, Dr. Zimmerman inspired the esteem and confidence of his patients, and the respect and good-will of his fellow practitioners. He had a great capacity for work and was conscientious even to detail. He found relaxation visiting his highly developed farm, and enjoyed association with real dirt farmers.

Of mature surgical judgment, highly skilled in his own right, he was not only a pioneer, but by keeping abreast of his profession, he was a leader in the surgery of his time. He did much in a personal way for the relief of human suffering, but his greatest contribution to humanity was the art he was able to teach those who were privileged to stand at the operating table with him.

BOOK REVIEWS

Peripheral Vascular Diseases. Edgar V. Allen, Nelson W. Barker, and Edgar A. Hines—all of the Division of Medicine, Mayo Clinic. W. B. Saunders Co. (Philadelphia)

For the past twenty years there has been great activity in the field of peripheral vascular diseases. In this volume the authors and their colleagues at the Mayo Clinic present in comprehensive form what is known in this field. As is stated in the preface: "Commonly, the term 'peripheral vascular disease' has been used to include only disease of the blood vessels of the extremities. Broadly speaking, however, the term should include disease of all vessels distal to the heart."

Following four introductory chapters which deal with definitions, gross and microscopic anatomy, diagnosis, and special methods of investigation, the following subjects and others are discussed: nailfold capillaries, Raynaud's Disease, Scleroderma, erythema-algia, Arteriol embolism and thrombosis, Arteriosclerosis, Periarthritis Nodosa, Aneurysms, Tumors of blood and lymph vessels, Thrombophlebitis, Varicose Veins, and Chronic Venous Insufficiency.

Of particular interest to South Carolinians is the fact that one of the co-authors (Edgar A. Hines) is a native of this state and his father, the late Dr. E. A. Hines, was for many years secretary of the S. C. Medical Association and editor of this Journal.

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TEN POINT PROGRAM CONTINUED SUPPORT THE VETERANS' CARE PROGRAM

The best evidence the medical profession can offer of its ability and willingness to solve the problems related to medical care, is the active participation by its members in sound, constructive projects for improving the distribution of medical care and toward making it available under more favorable circumstances to the people by whom it is needed. One such movement which has received the official stamp of approval of the South Carolina Medical Association is the program for out-patient services to veterans, under the contract entered into by the Veterans Administration and the Hospital Benefit Association, with headquarters in Greenville.

This agreement was approved in principle, and perhaps in detail, at the last state convention. The schedule of fees was drawn up and agreed upon as satisfactory by members of the association. Payment according to the schedule is assured under the terms of the contract with the Veterans Administration. The beneficiaries of the service provided under this agreement are a group who deserve the utmost attention and the highest quality and most immediate service.

But the program cannot succeed without the active cooperation of the doctors individually. We doubt that any real opposition on the part of members of the profession exists anywhere in the state, but indifference and failure to signify willingness to participate in the program may prevent its success and defeat the purpose for which it was designed. Here is an opportunity to show the constructive forces within the Federal Government, and those officials who are able to understand our language, that the doctors are ready and willing to cooperate. We take the liberty of suggesting that those who have overlooked returning the card to the Hospital Benefit Association signifying their willingness to participate in the program, should give the matter their attention at the earliest opportunity and send the card in.

NEWS LETTER FROM WASHINGTON

THIS NEWS LETTER affords the opportunity to introduce two newcomers in key positions in the American Medical Association whose job it will be to help with the prepayment medical care program:

Mr. Howard Brower, who has been discharged recently from military service, has joined the staff of the Council on Medical Service. His principal duty is to assist in the Division of Prepayment Medical Care Plans. He has had insurance experience, serving for six years with the Insurance Department of the State of Michigan, and as a member of the staff of a private insurance company.

Mr. L. S. Kleinschmidt has joined the staff of the Council on Medical Service and will pay particular attention to the rural aspects of prepayment medical care programs. He has a background of thirty-two years' experience in dealing with the public and in developing organizations for meeting special rural problems. During the past ten years, he has worked with state medical societies and lay groups in developing for the Farm Security Administration medical service plans designed to improve local rural

health.

A new type of NEWS LETTER comes to you at this time. It is printed in booklet form and gives the latest information on rural health activities in the states throughout the country. Here is a preview of 1947 rural health programs concentrating on extending the best possible medical service to all the people of America.

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AMERICAN MEDICAL ASSOCIATION

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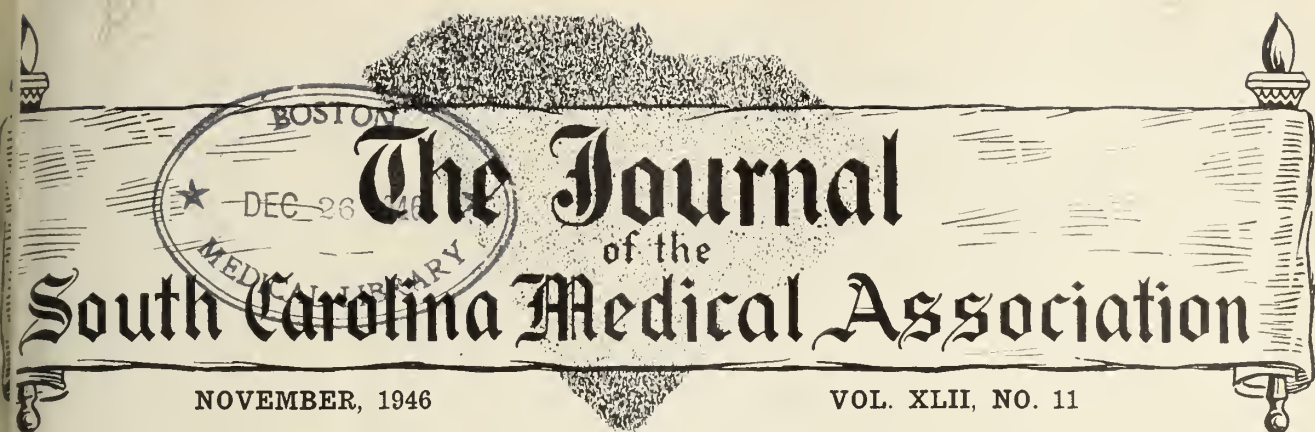
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Article	Author	Page
Intestinal Obstruction	Geo. E. Thompson, M.D.	295
Practical Suggestions for the Care of Obstetrical Patients	Arthur L. Rivers, M.D.	298
A Commentator's View of the Medical Dilemma	Upton Close	302
Remarks and Announcements	Kenneth M. Lynch	305
Editorials — The Ten Point Program — News Items — Public Health News — Woman's Auxiliary — Deaths — Book Reviews		

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1. Am. J. Surg. 44:288 (April) 1942.



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OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA
Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

November, 1946

NUMBER 11

Intestinal Obstruction

GEO. E. THOMPSON, M.D.
Spartanburg, S. C.

There is a story about a little girl, who when asked her age, replied: "I am 3 years old, but they keep changing it all the time."

During the past 40 years I have attended most of the meetings of this Society. They have been "changing" the program "all the time," many and different subjects have been discussed. However I do not recall that a paper has ever been presented with the title which I have chosen for tonight.

Many statistics have been presented on intestinal obstruction, and the mortality rate has been variously estimated, but it is probable that the death rate from all causes of which intestinal obstruction is the predominating factor hovers around 30%. Therefore it occurred to me that I might well present this subject for your consideration tonight, not that I have anything radically new to offer, but with the hope that some doctor present might bring out something in the discussion to follow. Obviously with a subject of such magnitude, I cannot dwell on any one phase at great length.

Forty years ago the opening of an abdomen was a little unusual in this county. Now it is the commonplace, and when a patient presents himself with signs of obstruction, we are apt to look for an abdominal scar. A larger percentage occur for causes other than previous operation, however, and a recent report from the Massachusetts General Hospital on 136 cases of intestinal obstruction states that only 30% of these cases exclusive of external hernia had had previous abdominal surgery.

Let us consider some of the other causes:

The presence of external hernia is usually known by the patient, and pain will be referred to the hernial site. In the absence of hernia, we think of adhesions and bands, and in the statistics quoted a moment ago, bands were reported as the causative factor in 81% of the cases. Occasionally we have

THE AUTHOR

A graduate of the Atlanta College of Physicians and Surgeons (1901), Dr. Thompson is now located in Spartanburg where he practices medicine and general surgery. He was Vice-President of the S. C. Medical Association last year.

large gall stones, mesenteric cysts, mesenteric thrombosis, or a diverticulitis causing the obstruction. Foreign bodies and tumors produce obstruction in the rare case, internal hernia in less than 10%. In the young infant with persistent vomiting, and dehydration, we consider congenital pyloric stenosis, or some other form of atresia of the intestinal tract; in the elderly, volvulus or malignancy. Endometriosis as a cause may be a possibility if the attack occurs in the female during the menstrual period.

The severity of the symptoms is not always a true index to the magnitude of the pathology present. All of us have doubtless seen a patient enormously distended, vomiting almost continuously, who at operation had no strangulation of the gut itself, but a small amount of omentum protruding through the hernial opening.

I recall the case of an old woman who came into the Spartanburg General Hospital about a year ago. The abdomen was much distended, and she was vomiting profusely. An enema was ordered and the removal of a fecal impaction by the nurse in charge relieved the patient.

When called to treat a patient with an acute abdomen, we are sometimes brought face to face with many diagnostic problems, as unfortunately there are many other conditions which may resemble intestinal obstruction. I have been tempted a few times to open what was apparently an acute abdomen, which later proved to be a cardiac condition with an abdominal mask. Most of us have seen rigid abdomens with much accompanying abdominal distress following insect bites, especially those of the black widow spider.

The vomiting, pain and rigidity of ureteral colic is hard to differentiate from intestinal obstruction occasionally, especially when our laboratory findings are obscured by a blockage of the ureter, although urine is obtainable from the affected side. Intestinal colic, gastric crises, and abdominal allergy may confuse us, but we are likely to discover simulating symptoms incident to acute disease early.

Then, the patient's history may mislead us as to the diagnosis, when he tells us that he has had a good bowel movement "last night or early this morning," while his distension belies the statement. Sometimes, student nurses and orderlies tell us that the patient has had a stool, when as a matter of fact he has only passed a residue, which was washed out by one or more enemas.

The truth is that patients sometimes pass considerable flatus when obstructed. Enemas can serve a useful purpose so far as the lower bowel is concerned, but, on account of the impermeability of the ileocecal valve in some instances, are of doubtful value in emptying the small bowel.

Wakefield & Fredell reported their experiments on trying to pass air and water from the ileum through the ileocecal valve into the cecum and vice-versa. They examined 75 specimens at autopsy, and found that air and water passed readily from the ileum into the cecum in all experiments. However when they attempted to pass water in the opposite direction, this valve tolerated pressures of 50 to 60 cm water in half the specimens, if rupture of the cecum did not occur.

In this connection I might say that I think more care should be exercised in the administration of enemas. (I believe that a fatality resulted in at least one of my cases from the use of too much force.) There is a tendency for the colon to retain less fluid after repeated enemas. However, the use of plain water as an enema allows the patient to retain more fluid, while the use of 10% sodium chloride enemas stimulates peristalsis.

Continuing our discussion of the diagnosis, when signs of obstruction are present, the biggest problem to be solved is whether it is a mechanical or a paralytic condition.

Thomas H. Russel says that mechanical ileus may be differentiated from paralytic by inserting the gloved finger into the rectum, the most favorable time being soon after the bowel has been irrigated. In case the condition is one of mechanical obstruction the gloved finger meets with resistance, but in the event that the condition is paralytic, the ampulla of the rectum is widely dilated.

Paralytic ileus is reported to present a silent abdomen, but the sounds of mechanical obstruction may be heard almost continuously through the stethoscope. Mechanical ileus produces cramps, but paralytic little pain if any. Intestinal colic pain is

somewhat relieved by pressure on the abdomen, but the pain of obstruction is increased.

We should bear in mind that many conditions outside the abdomen are known to produce ileus. Traumatic ileus may occur from disease or injury to other parts of the body such as pneumonia, brain injuries, fractures, etc. This might lead us to think that the patient with other injuries has sustained abdominal injuries also, when such is not the case.

The diagnosis of large bowel obstruction is perhaps more easily made than that of the small bowel. It is here that the barium enema may be of valuable assistance. However, barium should not be given by mouth to diagnose obstruction of the small bowel when an operation is contemplated in the near future.

A tumor mass can sometimes be palpated through the abdominal wall, or diagnosed through the proctoscope. Malignancy occurs more commonly in the left abdomen, and practically all malignant tumors of the colon produce an annular stricture sooner or later, if left alone. Some of these cases are not seen until obstruction occurs, or may present themselves on account of other conditions, and have a diagnosis made in course of a general examination.

We have read a great deal about malignancy in both lay and medical press, and heard much of it over the radio, within recent months, but cancer sufferers are coming to us still, when it is too late to materially benefit them by the known methods of treatment.

There are no doubt sign-posts on the road to malignancy that "even he who runs may read." This is true of the malignant bowel also.

One of the early signs is furnished by the blood picture of anemia, and the patient complains of weakness. There has been a change in the patient's stool habits, and there is obscure pain in the abdomen. He may have constipation and diarrhea alternating. He may have bloody stools occasionally or he may have a massive hemorrhage, all of which he may attribute to bleeding hemorrhoids. The presence of any of these symptoms, especially in later life, demand investigation.

The treatment of intestinal obstruction depends on the cause and condition present, but it may at any time become a surgical emergency. The Waganstein and the Miller-Abbott tubes have revolutionized the care of these cases. These patients are distended, and whether the obstruction is mechanical or neuro-genic, decompression is indicated, and it is well to employ tubal drainage in either event, especially if the diagnosis is obscure.

The Waganstein tube seems more adaptable for general use because of its easier passage, and because a larger lumen is available for drainage, than that afforded by the lesser lumen of the Miller-Abbott. Less skill is necessary to pass the Waganstein, since with the Miller-Abbott some experience is desirable.

Stein & McNeer of the U. S. Army described a rapid method of passing the Miller-Abbott by using mercury to increase its weight, and thus facilitate its passage. Dr. Franklin L. Harris of San Francisco presented a paper on the same subject. He attaches a small bag of mercury to the Wanganstein tube for a similar purpose. In the presence of mechanical obstruction these tubes are capable of doing harm, and I would emphasize this in reference to the Miller-Abbott. Either should be used guardedly.

How long shall we wait before surgical intervention? This may be a difficult decision to make in the given case. Decompression by tubal drainage, already mentioned, is indicated in almost all cases and the majority of patients will be helped by infusions and transfusions. When in doubt, it is at this juncture that the X-ray flat plate may prove of much diagnostic value.

Koucky & Beck classify the treatment of acute obstructions into three divisions: 1. Immediate operation; 2. Delayed operation; 3. Conservative treatment. They mention 48 hours as an arbitrary time, but conclude with the idea that conservative methods may at any time necessarily change to operative, and the proper time to make that decision depends on the diagnostic ability of the attendant.

Complete obstruction may be so much improved by the use of tubal drainage for the time being as to afford a false sense of security and lead the surgeon to defer operation. While some of the distension of intestinal obstruction is due to gas formation, a large part of it is due to swallowed air, and as patients swallow a good deal of air during anesthesia, the drainage tube should be left in situ when it is necessary to operate on the obstructed bowel.

To wait very late to operate jeopardizes the life of the patient and increases the hazards and difficulties of surgical intervention. Distended loops of intestine are poor media for anastomosis when that becomes necessary, and when covered with exudate are difficult to handle without rupture. When operating, if practicable it is better to approach the constriction by way of the collapsed bowel thus avoiding the handling of the distended gut, with its attendant dangers.

The obstruction of malignancy occurs most frequently in the region of the left iliac fossa. Exteriorization and a second stage anastomosis at a later date may be the procedure of choice.

The release of a constricting band may relieve the adjoining loop only to leave much remaining distension. The injection of an ampule of prostig-

mine methylsalicylate a few minutes prior to closing the abdominal wall facilitates the ease of closure in some instances but may be a dangerous drug to use in un-relieved mechanical obstruction. I believe that it is reasonably safe to use in paralytic ileus.

In all abdominal operations, to prevent future obstruction, the viscera should be handled as little as possible. To operate on a patient half anesthetized necessitates more or less traumatism and should be avoided.

Dr. M. G. Seely of St. Louis states that the common glove powder we use is a factor not only in causing obstruction but pre-disposes to cancer also and advises the use of potassium bitartrate instead of the silicates. Some surgeons think that the use of the sulfonamide drugs within the peritoneal cavity also produces obstruction in some instances.

Drainage as a factor in the production of adhesions is fortunately being seen less often than formerly.

SUMMARY

1. The patient with signs of intestinal obstruction is an individual problem and in making a diagnosis many possibilities are to be considered.
2. The decision between surgery and other methods of treatment at the proper time is an important factor in determining the prognosis.
3. If surgery becomes necessary the patient should be in the best condition obtainable under the circumstances.

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Practical Suggestions for the Care of Obstetrical Patients*

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Ideally, pregnancy is a physiological process, but actually pathological complications too frequently appear. This paper is to emphasize the clinical applications of procedures found practical in the practice of obstetrics.

Case history is as important here as in any other medical condition, particularly menstrual history and that of previous pregnancies. A careful physical examination should be made. The question of a vaginal examination on the first visit is debatable. I feel that this examination should be deferred until the tenth or eleventh week. By this time the patient is far enough along to make a diagnosis, it is early enough to correct any complicating pathology and there is less chance of precipitating an abortion.

Until the last month routine abdominal examinations at each visit are unnecessary. During the last four weeks the size, presentation, position and amount of engagement of the presenting part can be determined. Primigravida with small or borderline measurements, abnormal presentations, or lack of engagement of the presenting part should have x-ray studies including x-ray pelvimetry. These studies should show antero-posterior and lateral views including the sacrum and an estimation of the outlet with special reference to the pubic arch. Physical findings should be carefully evaluated with those of x-ray, but neither should be relied upon entirely.

Detailed instructions as to routine care should be given the patient. Such necessary information is too frequently neglected. Low heeled shoes, no tight garters, no douches or enemas unless specifically ordered, abdominal and breast support for comfort, light loose fitting clothing, no tub baths the last month. Activity should depend on what is usual for the individual, but no patient should take part in athletics. It is unnecessary to walk specified distances. Travel should be restricted. When necessary, plane or pullman should be used. This is especially true around suspected menstruation when the uterus is more susceptible to stimuli and interruption of pregnancy frequently occurs. All activity should be minimized around menstruation.

Weight gain of only twenty pounds is important and should be stressed, not because it affects the size of the baby but because it is a protection against toxemia. There will be less indigestion, more normal bowel elimination, and more general comfort towards

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the end of pregnancy if a moderately strict well balanced diet is followed throughout. Not many years ago patients were instructed to eat little or no protein for fear of kidney damage. It is now generally agreed that a lack of protein predisposes to toxemia and that the diet should be planned around a high protein intake. J. A. Williams states that "Protein deficiencies may lower the pregnant woman's nitrogen level, deplete the body tissues by utilizing them for normal protein needs, lower the serum protein level and lead to nutritional edema. By altering the colloid osmotic pressure of the serum protein they may predispose to toxemia of pregnancy. Anemia, poor muscle tone of the uterus, lowered resistance to infection and insufficient lactation may result." Green vegetables and fresh fruits will supply most of the vitamins and minerals needed. Carbohydrates should be restricted to a minimum. Skimmed or buttermilk will not increase the weight, but will aid in providing calcium and minerals. Calcium with vitamin D should be routine. Calcium, besides preserving the teeth and improving bone formation in the baby, decreases neuritis associated with pregnancy and aids the tone of uterine musculature. This increases the force of uterine contractions, shortens labor and minimizes bleeding after delivery. Both calcium and vitamin D aid lactation. If the neuritis is not controlled by calcium, large doses of thiamine chloride should be added until symptoms subside.

Anemia of varying degree in pregnancy is shockingly high even in so called healthy people. Iron should be given routinely. Adequate amounts of iron can only be given by mouth, and liver should be administered perenterally.

Laboratory studies should include routine Wassermann examinations, haemoglobin estimations, a red blood count and a study of a blood smear along with blood typing and Rh factor determination. Routine urinalysis at each visit should be done.

Patients known to have had syphilis should be treated during each pregnancy irrespective of the Wassermann report. Sulfa drugs must not be given as they pass through the placenta and the concentration in the baby is higher than in the mother.

The greatest tendency to anemia occurs around the sixth and seventh month. There is frequently

*Read before the Annual Session of the S. C. Medical Assoc., Myrtle Beach, May 2, 1945.

a diminution of erythrocytes out of proportion to the haemoglobin decrease. When the red count is lowered, liver parenterally in 15 unit doses twice a week causes marked improvement. Any patient who has a haemoglobin lower than 10 gms who does not respond to iron and liver therapy should have a transfusion before the onset of labor.

Whenever transfusions are indicated the husband should be used as a donor only in an emergency. Statistics show there are more frequent reactions to the husband's blood even though no apparent incompatibility is present. Besides the routine matching and cross matching, Rh factor determinations should be done.

In 1940, Landsteiner and his associates discovered that an agglutinable factor (Rh) present in the rhesus monkey also occurs in 85% humans (Rh pos) and is absent in 15% (Rh neg). Later it was found that Rh neg mothers and Rh pos fathers frequently produced babies with erythroblastosis. Further studies showed that 13% of marriages have Rh neg mothers and Rh positive fathers, yet the incidence of erythroblastosis is 0.1 to 0.2%. When it does occur there is some mixing of maternal and foetal blood due to permeability, defects, etc. The combination does not predispose to abortion but may cause premature delivery and stillbirths. Breast feeding is contraindicated. There is no definite agreement as to the best method of treatment of the Rh neg mother and Rh pos father combination. Some advise inducing labor as soon as the baby is viable to cut down the antibody reaction in the foetus. Others advise allowing the pregnancy to go to term and treating the baby by transfusion with Rh negative matched blood. It is debatable whether the difficulty of inducing premature labor and the strain of labor on the premature infant may not be worse than the possibility of erythroblastosis. I have delivered three normal children to one family of this type in two different instances; all were full term babies. Not infrequently the husband of an Rh neg patient is also Rh neg, in which case the baby will be all right. Whenever the mother is Rh neg, the husband should be checked.

The most important reason for having Rh determinations is in case transfusions are needed. Rh positive patients can have any matched blood. Rh negative patients must have Rh negative matched blood. Occasionally Rh positive blood can be given without reaction, but Rh negative women who need blood have a better chance of later having normal children if they are given Rh negative blood. Levine has found that erythroblastosis foetalis is almost twice as frequent among Rh negative women previously immunized by transfusions. All hospitals should have available Rh negative donors and physicians should check all females for Rh factors before giving transfusions irrespective of the age of the patient. There is no other way known at present to minimize the

possible complications associated with Rh negative individuals.

Morning nausea is a misnomer. The occurrence of nausea is variable and the time unpredictable. Use of sedatives, small frequent feedings, intravenous glucose and even termination of pregnancy are recognized treatments. Opiates are contraindicated. Vitamin B complex parenterally, especially thiamine chloride (B₁) and pyridoxine (B₆) has given dramatic results in some cases. I have recently used the treatment of "forced hydration" suggested by Eller and Randall. They base their treatment on the theory that nausea of pregnancy is due to the high serum concentration of the chorionic gonadotropin in the early part of pregnancy. This hormone is eliminated through the kidneys and the excessive water intake causes diuresis and decreases the concentration of the gonadotropin, thereby lessening the nausea. They further found that to be effective the water must be taken in specified amounts at specified times. A daily total of fifteen glasses should be taken; four between breakfast and lunch, five between lunch and supper and six between supper and bedtime. Hot or salt water may be more easily retained. If a glass is vomited, the patient must wait a few minutes and drink another. If the nausea is worse in the evening reverse the schedule. In the author's series 60% of cases were completely relieved. I have used it on twenty cases—fifteen were completely relieved within four days, three showed improvement and two found the treatment worse than the nausea and finally had to be admitted to the hospital for glucose.

During labor the doctor should "see what a patient can accomplish, not what she can endure." Strict asepsis is essential. Internal examinations whether rectal or vaginal should be minimized.

The patient should be instructed to eat lightly after labor starts as digestion does not function normally. Clear liquids may be given so as to prevent dehydration and aid diuresis, but if delivery is expected within four hours nothing should be allowed by mouth. If nausea is present, intravenous glucose not only settles the stomach and prevents dehydration, but also seems to stimulate uterine contractions.

Elimination of bowels and bladder should be carefully watched. A soda bicarbonate enema can be given if the membranes are intact and if delivery is not imminent. Frequent voiding should be encouraged. Unless extremely distended the patient should not be catheterized until on the delivery table. An empty bladder prevents bladder injury and persistent postpartum bleeding is frequently seen when the bladder is filled.

Sedation depends not only on the individual case but on the help available. The type of anesthetic for delivery is more important. Chloroform is still frequently used, but it is definitely contraindicated in any case of toxemia. When used for more than

a short time it frequently causes difficulty in resuscitating the baby. It predisposes to third stage and postpartum bleeding especially if uterine inertia is present. It has a very narrow margin of safety and except for its rapid induction and recovery has few good features. Vinethene is less toxic than chloroform and has a wider range of usefulness. Nitrous oxide oxygen, ethelene, cyclopropane are all good anesthetics and for the average case give satisfactory results. Ether is slower in its action, the baby is harder to resuscitate, and the frequent postpartum bleeding and prolonged anesthetic effect offset its wide margin of safety. The addition of novocaine infiltration before an episiotomy greatly reduces the amount of anesthetic during the repair.

The choice of episiotomy depends on the perineum. If the perineal body is sufficiently wide a mid-line incision can be safely used. If there is any doubt a medio-lateral incision is much safer and will not extend into the rectum. The method of closing the episiotomy is important. As few sutures as possible should be used to closely approximate tissue. These should be tied loosely so as to prevent ischemia. Chromic catgut #0 or #1 should be put in as interrupted sutures in the muscle. A continuous suture of the same material is put in the vaginal mucous membrane ending with the edges of the hymen in their normal approximation. If these hymeneal edges are correctly approximated the skin edges will fall together more easily. The skin is then closed with interrupted black silk vertical mattress sutures. When the skin sutures are cut they should be sufficiently long to bend over so that they do not stick the patient. The skin sutures are removed on the fourth or fifth day. Four percent mercurchrome is instilled into the vagina twice a day until the sutures are removed. This prevents infection, and the added moisture keeps the patient more comfortable. If there is discomfort after the sutures are removed, heat applied to the perineum with an ordinary reading lamp gives considerable relief.

The status of ruptured membranes has changed considerably in the past few years. At one time it was thought that if the membranes ruptured the patient would have a prolonged "dry labor." It is now agreed that rupture of the membranes speeds rather than retards labor. In my opinion, an evaluation of the cervix is important in determining if and when the membranes should be ruptured. In other words the cervix is either favorable or unfavorable for artificial rupture of the membranes. A favorable cervix is soft, partly effaced and dilated. An unfavorable cervix is long, firm, tightly closed. The presentation, amount of engagement as well as period of gestation must be carefully considered.

Uterine inertia results in prolonged labor, exhaustion of the patient, more chances of infection, fetal asphyxia, more frequent postpartum hemorrhage and

the temptation to interfere before the cervix is completely effaced and dilated. Prophylactic treatment is the best. Proper prenatal care with adequate nutrition, especially protein, along with calcium and iron and vitamins will aid in preventing inertia. Those cases having a previous history of prolonged labor seem to be helped by the administration of estrogens in small daily doses two to three weeks before the expected date of confinement. The results of such treatment are questionable because no two labors are ever the same irrespective of medication. I have successfully used stilbestrol in one mg doses daily for three weeks before confinement in cases having previous prolonged labors. No bad effects have resulted so far. Careful evaluation of the type of labor before administration of sedative will help prevent inertia. Too heavy sedation in cases of poor labor makes a bad situation worse. This is especially true of opiates and rectal ether.

The curative treatment of uterine inertia is much more difficult. It is essential to determine if there is any pelvic dystocia present before attempting to stimulate the uterine contractions. Castor oil, quinine and hot enemas are of some value. Adequate fluid intake to prevent dehydration and glucose intravenously when the patient is unable to take fluids by mouth aids the strength of contractions. Oxytocic drugs can be used, but indiscriminate use is extremely dangerous. Ergot preparations are contraindicated since the resulting stimulation is too prolonged, may injure the baby, or even cause rupture of the uterus. Pituitary drugs when cautiously used improve contractions. The initial dose should be one minim and the doctor should watch the reaction before ordering subsequent doses. Such a dose can be repeated every half hour for a total of six doses if no bad reactions result. Never under any circumstances should more than two minims of pituitary products be given before the baby is delivered. I have seen one minim of pitocin produce a contraction lasting ten minutes, necessitating the use of an anesthetic to relax the uterus.

Recently most encouraging results have been obtained with the use of calcium intravenously. Calcium gluconate (10cc 10%) or calcium chloride given very slowly, not over 1cc per minute, every six hours, acts as a uterine stimulant and as a synergist to oxytocic drugs.

As soon as the second stage is reached the patient should be delivered by forceps. The two main indications for forceps are maternal and foetal. Convenience is not an indication either from the standpoint of the doctor, the patient or the relatives. There is no more valuable instrument in obstetrics than forceps and probably none more abused. Proper application with a steady pull exerted during a uterine contraction will require less force to the pull and cause less trauma to baby and mother.

Many babies are lost or have permanent injuries

due to shoulders hanging up during actual delivery. The frequently advised method of downward traction on the head to dislodge the anterior shoulder from beneath the symphysis many times results in hematoma in the neck muscles and injury to the brachial plexus. The following technique has been suggested and I have used this method many times with good results. The patient has the thighs flexed on the abdomen; constant and gentle pressure is exerted on the fundus by an assistant; the index and middle fingers are placed on the anterior surface of the clavicle that is posterior. Pressure is exerted so as to rotate the posterior shoulder anteriorly in the direction of the baby's back. In other words if the right shoulder is posterior, pressure is applied in front of the right clavicle and the right shoulder is rotated clockwise to bring it under the symphysis. If the left shoulder is posterior pressure is exerted in front the left clavicle and rotation is counter clockwise to put the left shoulder under the symphysis. These maneuvers "unscrew the shoulders" as a bolt is unscrewed from a nut and there is less damage to the baby and to maternal soft parts.

The complication of occiput posterior positions is not as serious as is generally believed. Many posteriors would rotate spontaneously if there was adequate force to the uterine contractions along with proper use of the auxiliary abdominal muscles. For this reason it is essential that as little sedation as possible be used so as not to retard or lessen the force of the contractions. The use of opiates should be minimized. Once the rhythm of the labor is upset by the use of sedatives, it is difficult to re-establish active labor again. In spite of all treatment, difficulties occasionally develop.

The amount of blood lost at delivery and immediately postpartum is variable. The effect depends on the condition of the patient. Any excessive bleeding should cause apprehension and treatment should be instituted immediately. Mechanical means of massage and upward traction to put tension on uterine vessels will aid in controlling bleeding. Oxytocics along with calcium intravenously act as synergists and control many such hemorrhages. Uterine packing seldom does much good and it is debatable whether it may not cause shock and predispose to infection. Fluids intravenously along with plasma will prevent serious shock until blood can be given. It is essential to treat shock before it becomes so severe as to impede the treatment or has become irreversible.

Care of the baby after delivery should not be over zealous. Preventing or removing obstruction to respiratory passages is important. As the baby's head is being delivered a gauze sponge placed between the labia and the baby's mouth prevents amniotic fluid being inhaled. A long tipped rubber ear syringe will remove the mucus, etc., from the mouth and throat and the friction of the syringe

on the back of the throat causes the baby to cough and stimulates breathing. A tracheal catheter works just as well. Suction machines should not be used. Friction up and down the spine with the fingers stimulates respiration. Isaac Abt of Chicago says "any of the old treatments such as spanking, violent artificial respiration, cold baths, dilatation of the sphincter and Schultze's swings should be obsolete."

It is now believed that stimulation of respiration should be of a mechanical nature. The use of drugs is becoming less popular. Alpha lobeline, coramine and metrazol have all been used. Metrazol appears to be the least toxic and has fewer complicating side effects. Resuscitating machines when properly regulated are extremely valuable.

Administration of vitamin K during labor and postpartum to the baby is being more widely used. I use it routinely and have found no bad effects.

Restriction of visitors to husband and one other person for five days after delivery has increased the proportion of nursing mothers. Routine use of vitamin A and D ointment to the nipples has decreased fissures and sore nipples as well as mastitis. If mastitis does develop, the breast should be tightly bound, ice used for comfort and sedatives as indicated. The use of camphorated oil, heat, and massage is obsolete and dangerous. The use of estrogens is now widely advocated. Stilbestrol mgl two or three times a day until pain is relieved is the usual dose. My experience has been that the use of estrogens frequently upsets subsequent menstruation and results in increased bleeding. I have reserved its use to those cases having excessive congestion and pain after breasts are tightly bound.

Inability to void is another postpartum complication. The use of prostigmin 1-2000/1cc every hour for six doses i.m. will usually bring results. If this does not work and the patient needs to be catheterized, one drachm of 4% mercurochrome instilled in the bladder acts as an irritant and stimulates voiding. A urinary antiseptic given at the same time prevents infection. If the patient has not voided by three days, a retention catheter should be left in the bladder with continuous drainage for 72 hours. Most cases respond to this treatment.

The pendulum in postpartum care is swinging to shorter convalescence. I feel that involution is a relatively slow process and if activity is begun too quickly there will be more morbidity and more chance of infection.

In conclusion—merits and demerits of some everyday obstetrical procedures have been presented. The lot of the expectant mother, the parturient woman and the newborn infant will be improved when doctors understand the importance of an obstetrical conscience.

A Commentator's View of the Medical Dilemma*

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It is a great honor to me to be invited to lead off a discussion with you. I am going to do it in the spirit of a forum. You know a lot more about the answers than I do.

I am going to give you what is the essence of a little look I have had into the Wagner-Murray-Dingell Bill and the forces that lie behind it. I found myself getting into what seemed to be just the very inside of the real plan to substitute state Socialism for the American system of enterprise and government.

I wondered first of all why the stateists pick you doctors as the soft spot for the entering wedge. Why didn't they pick the lawyers? Why didn't they use them as their cutting edge of the wedge to get into the professions? They chose to let the lawyers alone. Lawyers are pretty tough. They are a little more worldly wise. Then it seemed to me there were other reasons perhaps. Under the word "stateists" I group the state socialists of all types from the well-meaning "do-gooder" who calls himself a Christian Socialist, to the completely ruthless full-out Marxist who believes in revolution by force, the abolition of all standards of what we have known as honesty, ethics and truth, and the use of any form of lying and misrepresentation and taking advantage of his victim's basic honesty in order to undo him. Our stateists very carefully survey the field before they move. I find that their move on medicine is nothing new. It has been under preparation for a very long time. The first bill prepared under the title of Wagner-Murray-Dingell was back in 1943. In 1944, Mrs. Eleanor Roosevelt came out in favor of this idea. In 1944 and 1945, the labor unions began getting behind it, first the CIO and eventually the A. F. of L. leaders. Then, when the ground had been very well prepared, a whole flock of bills which have associated with them the names of Wagner, Murray, Dingell, or Pepper, appeared in Congress. One of those bills was passed by the House only the other day. Probably you didn't even notice it. It was slipped through in a hurry, a ten million dollar grant for psycho-neurotic clinics. Some medical men favor these grants-in-aid so long as they are administered by the local authorities. I think that

is a question which deserves a good deal of consideration and discussion.

How far will the medical profession and individual doctors want to go in favor of these grants-in-aid? You may be sure that the people who are trying to set them up, good as they may be in principle, are the same people who are behind the overall bill for state medicine—exactly the same people. Their aim in both cases is the same. The grants-in-aid scheme is probably, from their point of view, a greasing of the wedge they are going to put in. Undoubtedly they intend that these grants-in-aid shall fall under the administration of people of their own stripe. I don't know what is going to happen to ten million dollars for psycho-neurotic clinics provided the present bill gets through the Senate, but you can imagine that it might fall into the hands of a number of young professors, each one setting out to use some of the government's money to test out his own particular theories on a bunch of poor guinea pigs who happen to come under his control.

There is a whole flock of bills, all of them put out by this same group, designed to hammer away on a number of different fronts. One of them concerns the problem child—the so-called Pepper Bill. It is disguised as a medical bill. It is not a medical bill; it is a bill to give the state or its social workers control over a certain proportion, or maybe 2%, of the youth of America under the guise of their need of medical attention. Under that bill, if it should pass as I read it, anybody could go to the local authorities and claim that Johnny Jones was not being properly raised by his father or his mother, and soon Johnny Jones would be under the control of the state, and his parents would have lost control of their own child.

Now, the first thing that strikes a layman in studying this whole measure is that none of these bills originated with medical men. I can't find any evidence that a single one of them originated with the medical profession or even from laymen who are particularly concerned with the health of the nation's people. These bills originated from politicians, not from medical men. They were drafted in their present forms, which are just about the worst conglomeration of vagueness and double meaning any one could possibly get into the English language, by fifty-odd specialists in the Department of Social Security. When the hearings were held on the bills in Washington, I am told, these men passed back

* (This address by the noted commentator and news analyst, Mr. Upton Close, was presented at the annual Conference of Presidents and Other Officers of State Medical Associations in San Francisco, June 30, 1946.—Ed.)

and forth between their own files in the Social Security Administrative offices and the Senate offices where the hearings were being held, carrying with them huge quantities of material, files of one kind and another. They engaged in rude interruptions during the testimony; they acted as if they considered themselves part of the investigating committee—which in effect they were, of course.

Now the question boils down to this in my mind: Is this whole effort to institute state medicine and all of the specific presentation of it something coming from men whose profession is to be concerned with the health of the nation and something which, therefore, is intended to benefit the health of the nation? Or is this effort originating from men with a political purpose who aren't primarily concerned with the health or welfare of the nation at all, but who are merely taking advantage of an opportunity that exists, perhaps, because of resentment and dissatisfaction with the cost of medical attention and hospitalization? The question of whether the motivation is political or whether it is the welfare of the public and the individual should be highlighted to the American public with a thousand times as much candlepower as it has had.

I have often wondered just how the medical profession regards itself, anyhow. I was trying to get myself boned up on some figures. I found a lot of conflicting figures as to what the investment of you men in your profession amounts to. Take just the 125,000-odd members of the American Medical Association. (I believe there are 70,000 or 80,000 others recognized as M.D.'s.) But considering the 125,000 A.M.A. members—suppose their education cost them \$25,000.00 each. I should think that would be a conservative figure, wouldn't it? Suppose their equipment, when they get into practice, is worth \$15,000.00 each. That is a \$40,000.00 investment. That means five billion dollars of capital invested in the medical profession, just for training and equipment! A firm in the business of putting up electrical wires would say—what does it cost to provide service? What is the capital investment? If you are going to figure a 6 per cent interest on your capital investment, it amounts to three hundred million dollars a year, or \$2,400.00 for each of the 125,000. Now I saw in a statement from the A.M.A. that the average income of the doctor was \$5,000. Twenty-four hundred dollars of this is just interest on capital investment! That leaves him on the average, about \$2,600.00 actual earnings for the year. Something is wrong! I don't know what it is, but I don't believe men of your caliber should be working for me or anybody else for \$2,600.00 a year!

I have read from government figures used by these social welfare workers, that six or seven billion dollars a year is spent by the American public and government now on public health. Who is getting it? If the doctor is making an average of \$5,000.00

a year, he is certainly getting a very small cut of the amount being spent on public health, isn't he? The doctors, according to these figures, get only six hundred and twenty-five million out of seven billion spent annually.

Yet the doctor is getting most of the blame for the cost of people's sickness. Apparently a very, very small proportion of money spent on ill health goes to the doctors. The bulk must be going to hospitals and for medicine. I don't know where else it is going. It seems to me that these figures ought to be cleared up in the minds of the public before they are asked to decide whether the doctor is going to be made an agent of the government, and his freedom to practice as he wishes taken away from him.

I have a lot of other questions I could ask, but they add up to the fact that it seems to me that M.D.'s are taking about as poor care of themselves as any group of professional men or workers in the country. This is a day when we have to take group care of ourselves or just get trampled under. This is a day when it is recognized as politically and morally ethical for shipworkers or streetcar workers or anyone else to strike and quit work if they don't like the conditions. Our present government endorses the right to strike regardless of the public's discomfort because of it. And yet, here is a group of men representing an investment of five billion dollars who allow themselves to be badgered and told by some officials in Washington that it is very wrong and wicked for them to talk about refusing to work under conditions which may be arbitrarily imposed on them. I don't know any professional men or laborers in any other walk of life who are going to work under conditions that they regard as slavery, and I think that the public at large is not going to have much respect for the men of any profession who let themselves be badgered that way. I think the public would have far more respect for doctors if they would say: "The streetcar worker strikes against you whether you are sick or not, whether you are crippled or not, or whether you will starve without transportation to the job or not. We are not going that far. We are not going to strike against the public. We are going to continue to offer our services to sick people on exactly the same terms as before, but we are going to refuse to work for and under an administration arbitrarily set up over us, one that we have not willingly accepted." As an outsider, it seems to me this would kill the whole project, the whole political project of enslaving the medical profession and making it part of state bureaucracy.

You know that all of the things that have been promised to the patient in these pending bills are proved untrue. They are proved untrue now in Germany. They are proved untrue in England. Right now they are being proved untrue in New Zealand where there is a movement to turn medicine back

to the individual doctor after the state has emptied its treasury on it. You know the fallacies in the presentation that people get better and cheaper medical care if the state, if the politicians, control it. These untrue statements should be made much plainer to the common people in America, and you are doing us a disservice by not reaching them and telling them these things. The enemy is filling them full of this stuff. Every day seven or eight broadcasters over the networks are feeding it out because their hearts are in the socialistic scheme. How many broadcasters have you got feeding out to those same audiences the correction of these lies? That is a job of public relations and it is also a job of self preservation.

So, here is a profession representing a huge investment (an investment necessary for the welfare of the people) which certainly ought to be in an organized form exercising its rights to say what kind of conditions they will work under—just as General Motors management says what kind of conditions it will work under and what kind it will close shop under; just as the employees of General Motors say what kind of conditions they will work under and what kind they will close shop under. If the medical profession would do that, the scheme of the politicians for using you as the soft and sappy part of the American body politic into which they can drive their wedge of socialism would be deadlier than a dodo. Right then and there it would die, because you can't have socialized medicine without doctors. Why fool around? The men who are against you are very powerful. They don't care about your investment. They don't care about the public's health, really. They are the same kind of men who put over Communism in Russia, and they put it over even though they had to kill twenty million people to do it.

There is one thing you doctors have to recognize, and that is, you have a Trojan horse inside your ranks. I have run into him, I have been bitten by him, kicked by him, several times already. There are non-doctors in charge of some of your organizations, who help to hold you in leash, by telling you that you cannot ethically take a stand in your own protection. You medical men must be the judges of your own ethics. Remember that Marxists make a boasted policy of trapping honest men through their own ethics.

I feel that developments on the voluntary basis are the finest counter to the despotic basis: such magnificent beginnings as Doctor Brunk's Michigan plan. Yet this can have certain forces inside it trying in every way possible to bring state medicine. Gentlemen from these forces may happen to be on the board of this, that, or the other voluntary plan, and they are going to block any scheme for getting to the public with the true objections to that plan. If the wishes of these gentlemen are going to be

honored, then, my friends, you are sunk. You are finished, because these gentlemen who comprise the 10 per cent Trojan horse among you, know what they want. What they want is to regiment you under state officers, and they are going to stop anything that hinders that development. They are going to stay in your organizations pretending they are of you, but stabbing you in the back. They are going to be in there working, and if 10 per cent can block the wishes of 90 per cent to fight state medicine, then you are going to have state medicine!

Now it seems to me there is one other angle of public relations that doctors need help on. You know, the doctor is like the commentator. People write nasty notes to the commentator because they don't like him. The doctor is likely to get the idea that everybody loves him. Well, a lot of people do love him and, perhaps, personally and individually, everybody loves him. But the public doesn't love the medical profession, I am sorry to say. It seems to me that a lot of study should be given to the reasons for that. I wonder why the A.M.A. and groups of that sort do not set up very careful committees to study the question of what complaints the public has against the medical profession which are being formed into a crusade to put over state medicine. I have had a lot of experience with M.D.'s. I have often been ill in tropical countries. I was trying to think what it is that I have in *my* heart against doctors. Well, for one thing, absolute bafflement! I go to six or eight doctors, maybe, about the same lot of symptoms, and I get six or eight different diagnoses, and I wonder, are they just guessing?

I realize that it is difficult for doctors to deal with the public today because so many patients are psychoneurotic when they go to the doctor's office. If the doctors tell them the trouble is in their heads, they get mad at the doctor, and if he tries to give them something to cure them that doesn't work, they get mad at him just the same. So there it is. But if there is any way to eliminate this bafflement of the public, it would be of great use to the profession. Again, you run into cases where overspecialization seems to be the trouble. It might be that there was a failure on the part of a gynecologist and a urologist to get a proper diagnosis of a case. So each one went ahead treating what he saw, and there was a terrible expense and long months in the hospital. All that will be laid at the doctor's door. Well, maybe there is a way to get more general supervision over the specialist for the sake of the poor guy who comes in and doesn't know what is wrong with him or his wife. I don't know. That is your problem.

Then again, I have heard complaints that the rich man is all right; he can afford it. The poor man gets wonderful public care by good and charitable doctors. But the middle class man is paying the bills, is paying more than he can afford. These

complaints are taken advantage of by the people who want to introduce state medicine. It might be possible to rectify to some extent these difficulties, but above all, it is possible for doctors to go out and tell their story to the public and get its sympathetic ear. If the story about the difficulty a doctor meets because of the psychoneurotic condition of so many patients were told to radio audiences, for instance, the public would say: "He is doing the best he can, and if state medicine came in, he couldn't do any better—might even be hampered."

I am convinced that the ultimate and best defense against state medicine is the voluntary medical insurance plan. I don't understand the distinction between non-profit plans and profit plans. I suppose the doctor has to get paid in any case, and I think he should be properly paid. I think he should be much better paid than was suggested a week or so ago that he be paid in England. I notice that under the new English plan a doctor would start with not less than \$2,000.00 a year, and by the time he is fifty years old, he will be earning \$10,000.00 a year. That is state medicine for you, and no wonder the British doctors are beginning to rebel and are signing a pledge that they won't work under it. The doctors have to be paid in any case, and if there is a selling service, that has to be paid for, too.

I don't know what you mean by profit or non-profit, but the very best way to combat state medicine is to go out and sell the people something better. Tell them why it is better, tell them it is

voluntary, it is in accord with American traditions. The other thing is not American, it is Communistic, it is Marxist. Show them what they get for money they put in. Tell them that if they want medical care, here is a way they can buy it just as they pay for their life insurance. It won't be taken out of their wages by their boss, under the direction of a tax collector! *Sell* them something.

In other words, I think a great job of public relations is needed. Start fighting! You are going to find such organizations as CIO-PAC, the social workers and the "do-gooders," the Communists and the half-Communists and the "pinkos"—you are going to find them too much for you unless you get out and fight. First of all, tell them pointblank and in an organized fashion—and enough of you to make it count—that you won't work for them. The public would applaud that! And cut out this nonsense that you aren't allowed to say anything in your own defense. Secondly, there are problems and difficulties with your patients. They go around complaining; well, why don't the doctors do some nice complaining about patients? Turn the tables; ask them for their understanding; tell them what a doctor is up against. And thirdly, sell them something better in place of state medicine. There is no use being reticent about it. Buy radio time and get out and sell it for the simple good of the people. If you let them know it is there, they can buy it if they want to. If you sell what you have, I don't think the Wagner-Murray-Dingell Bill will have much popular support.

REMARKS AND ANNOUNCEMENTS

By

KENNETH M. LYNCH, M.D., DEAN

(Medical College of the State of South Carolina, Opening Exercises, September 26, 1946.)

The fourth Thursday in September has returned to us as the day when the school bell rings for the beginning of another term of formally scheduled educational work, this opening exercise being the 120th of the Medical College.

Four years ago with the beginning of the war time accelerated year-round schedule our dates became lost, and the school bell rang so much and so long that it lost some of its appealing tone. That is now in the past, and I hope will not return. The Medical College is now on an even keel of normal operation.

The time is not long ago that the opening and closing of a medical school periodically signified just that. There was a period of about four months when at least the most of the activities of the Medical College were really closed and a large part of the plant literally deserted.

That is no longer so. Except for the absence of

the bulk of the students, this summer one could not tell that the College was not operating in full blast.

That difference between the past and the present is because the functions, the workings of a medical school are no longer limited to the conduction of a formal educational schedule. Informal, postgraduate and special educational endeavor goes on constantly, as does a variety of research and public service activity. The Medical College is and will remain in full operation the year round.

Formerly this occasion of today was one not only of welcoming the students but of reunion of the faculty. There is hardly one of the latter here today who I have not seen almost daily throughout the summer.

This therefore becomes peculiarly an occasion for us of the teaching staff to see and to welcome in a body the members of the classes in nursing, pharmacy and medicine. Those who have been here before,

we are happy to see again. To the new recruits we extend a hearty welcome. To all we offer ourselves for your service throughout the remainder of your lives.

ANNOUNCEMENTS

As we go along in the normal course of procedure we will have natural losses and gains in the teaching staff. A president of Harvard once said that he considered his salary well earned if he found one worthy recruit to the faculty a year.

This year the Medical College is fortunate in having back in its service those of the permanent staff who had been absent in active military service, including Dr. Olin B. Chamberlain, who has become full-time Professor of Neuro-psychiatry, Dr. Pierre G. Jenkins, Dr. Archibald J. Buist, Dr. I. Ripon Wilson, Jr., Dr. Edward F. Parker, Dr. James O'Hear, Dr. John H. Murdoch, Jr., Dr. Henry C. Robertson, Dr. Thomas W. Reynolds, and Dr. Hampton Hoch.

Additions to the full time staff are several: The professorship of physiology has been accepted by Dr. Theodore G. Bernthal, who will take up his duties within a few days. Dr. Bernthal secured his degrees, B. A., M. S., and M. D. at the University of Michigan. After serving an internship at the Rochester General Hospital he advanced through the ranks at Michigan to the position of Assistant Professor of Physiology from 1932-40, and then to that of Associate Professor at Vanderbilt University from 1941 to the present.

Dr. Bernthal has arrived at a position of high repute in the medical teaching and research world and the Medical College is very fortunate in having him join its staff.

Dr. Edward E. McKee, a graduate of the University of Pennsylvania, who served an internship at Pittsburgh and then was associated with the department of pathology at the University of Cincinnati from 1941 to 1943, when he joined the Army, has just been released to accept his appointment as Instructor in Pathology.

Dr. William D. Hazelhurst, a graduate of Vanderbilt University, who pursued his postgraduate training in medicine at that school and here, and who served in the U. S. Public Health Service, has been appointed Associate in Medicine.

Dr. James M. Wilson, a graduate of this school who accomplished a postgraduate experience at Duke University before serving in the Navy, has assumed the duties of his appointment as Associate in Obstetrics and Gynecology.

On the debit side of our ledger, Dr. Walter L. Hard, Associate Professor of Anatomy, has left the faculty to accept the chair of anatomy at the Uni-

versity of South Dakota, and Dr. R. C. Stokes, of the Pharmacy faculty, has resigned to become associated with the University of South Carolina.

This year will see the largest enrollment the College has experienced, with 187 students in the School of Nursing, 75 in the School of Pharmacy, and 215 in the School of Medicine, a total of 477, not to count a number of veterans and others now attached to various departments in postgraduate or technical study.

To all of the new students, I wish to call attention to the fact that you are now participants in the honor system which the student body and faculty administer in examinations and in general conduct. If you have not already secured a copy of the rules of this system, please obtain it from the Registrar.

To the entering class in medicine there is an item of particular interest. You will each receive a letter stating that unless the College shall be at least assured of the provision of full clinical teaching facilities for the number in the class by the time of your arrival at that phase of your course, the class may have to be reduced.

Before the war the College admitted only 42 to the first year medical class. During the war, under pressing demand from several quarters the class was increased to 50 and then to 60.

The increase was involved in the so called Medical College Expansion Program. This includes a new teaching hospital, in addition to the full facilities of the Roper Hospital, and completion of the quadrangle of the College plant proper.

The State Legislature has appropriated \$1,500,000 toward this purpose. The Federal government has made an appropriation and allotment to this State within the scope of which comes such a project.

Unfortunately for any immediate use, these commitments do not agree in the particular of ratio between the two. While probably no immediate building could be done anyhow, it is important that we shall secure an agreement which will allow us to proceed when building conditions shall permit.

There is no person nor any body of people to whom this matter is of greater importance than the students of the school. It is for their particular benefit, and without success in it they would be the immediate losers. For that reason I hope that you will all seriously consider that you can be of help in continuing our efforts of the past two or three years toward complete success in possessing fully adequate facilities to do well our job for the State and for medicine in all its phases.

The Journal of the South Carolina Medical Association

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Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Florence, S. C.

Subscription Price

\$3.00 per Year

NOVEMBER, 1946

WHAT HAVE WE DONE?

In May 1944, our Association adopted a specific plan of action—known as The Ten Point Program—and on September 1 of the same year it was put into effect. Now that two years have passed, it is only right that we should look back over the twenty-six months and ask ourselves the question, "What have we done?"

During the past two years our Association has:

(1) Working with the Dean of the Medical College and his Advisory Committee, and with the Board of Trustees of that institution, secured from the General Assembly an appropriation for a much needed expansion of the Medical College.

(2) Worked out an agreement with the Veterans Administration whereby veterans with service connected disabilities can be cared for by their own physicians in their own communities.

(3) Joined with the South Carolina Hospital Association in securing enactment of legislation making possible the establishment of a statewide hospital service ("Blue Cross") plan.

(4) Joined with the Hospital Association and others in making provision for a state-wide hospital survey. This survey is being made by the State Planning, Research and Development Board. Three members of our Association are serving on the Advisory Hospital Council to this Board.

(5) Carried out an intensive program of education of the public in behalf of a voluntary system of medical care as opposed to a federal system.

(6) Aided communities in securing needed physicians and assisted physicians in finding locations for practice.

(7) Increased the membership of the Association to an all time high, with slightly more than one thousand members.

(8) Established the Association as a potent voice in matters dealing with the medical and general welfare of our people.

(9) Assumed an important place on the national platform of medical affairs through representation

and participation in national conferences and organizations.

(10) Laid the foundations for greatly increased activity in the coming years.

The above listed accomplishments may fall short of what might have been done but they give adequate proof of the desire and ability of our Association to plan and work for the public good. It is true that certain of our leaders deserve much credit for what has been done, but their work would have been of little avail without the support of the members at large.

HEART DISEASE AND TUBERCULOSIS

(That statistics may suggest one thing to the casual reader and another to the student is well illustrated by the following editorial which appeared in the Oct. 4, 1946 issue of Public Health Reports. It bears out the fact that although heart disease should receive our great attention, no letup should be made in our fight against tuberculosis.—Editor)

Heart disease was the cause of 418,062 deaths in 1944, or 30 percent of all deaths reported for all ages in the United States. Tuberculosis was reported as the cause of 54,731 deaths, or 4 percent of all deaths in all age groups. Since 1934, deaths reported as caused by heart disease have increased from 303,724 to 418,062 in 1944—an increase of 38 percent over the annual deaths due to heart disease in 1934. In the same period, tuberculosis deaths declined from 71,609 in 1934 to 54,731 in 1944—a decrease of 24 percent.

This seems to indicate that heart disease is increasing in significance as a cause of death in the population as a whole, while tuberculosis is declining in significance. This is true for the entire population, on the basis of reported deaths, provided that these figures do not lead us into a misconception of the relative importance of tuberculosis as a cause of death among certain age groups. A study of data on age specific death rates discloses that, contrary to the impression given when deaths among people of all ages are considered, tuberculosis still stands

out as a leading cause of death among the most important age group of the population—persons between 15 and 44 years of age. Here it is noted that tuberculosis was reported as the cause of death in 26,942 cases while diseases of the heart were reported as the cause of 25,705 deaths out of a total of 185,131. There has been no change in this relationship since 1943.

Any consideration of deaths in the total population may indicate that heart disease should receive the greatest attention. A careful weighing of the facts, however, will lead us to increase and not decrease the force of our attack on tuberculosis, which kills even more persons than heart disease in this principal productive and reproductive age group. This is not to say that heart disease among persons of 15 to 44 years of age should be neglected. On the contrary,

equal emphasis should be given the problem. However, unlike heart disease, tuberculosis can be effectively controlled, and available methods for that control must be utilized to the utmost and at once. The program of case-finding and follow-up should be expanded rapidly. Only in this way will the morbidity and mortality of tuberculosis be reduced. It is particularly important that the disease be eliminated among the people 15 to 44 years of age. This group constitutes our reservoir of population replenishment and is the source of our most vigorous labor supply. The continuation of a nation's vitality depends upon the health of its people. We must put an end to the costly neglect of known control methods and take up positively the offensive against a disease that kills the young, the hopeful, and the strong.

PROGRAM
FIFTH ANNUAL POST GRADUATE SEMINAR
ALUMNI ASSOCIATION
of the
MEDICAL COLLEGE OF THE STATE OF SOUTH CAROLINA

Tuesday, December 3, 1946

9:30 A. M.

Dr. Wayne Babcock, Professor of Surgery, Temple University, Philadelphia—"Malignant disease of the intestinal tract, its recognition and treatment."

10:30 A. M.

Dr. Dallas B. Phemister, Head Department of Surgery, University of Chicago—"The treatment of malunited and ununited fractures."

11:30 A. M.

Dr. A. R. Shands, Medical Director du Pont Institute, Wilmington, Del.—"More common affections of the shoulder and knee, their diagnosis and treatment."

Clinical Case Presentations

12:30 - 1:00 P. M.

Dr. F. E. Krcdel—Discussion by Drs. Babcock and Phemister.

1:00 - 1:30 P. M.

Dr. F. A. Hoshall—Discussion by Drs. Shand and Paul Magnuson.

Round Table Discussions

3:00 P. M.

General Surgery—Drs. Babcock and Phemister.

4:00 P. M.

Orthopedic Surgery—Program arranged by the Fracture Committee of the American College of Surgeons for South Carolina featuring Dr. Paul Magnuson, Head of Veterans Administration Surgical Service—former Professor of Bone and Joint diseases, Northwestern University, Chicago.

5:30 - 7:30 P. M.

Fort Sumter Hotel, Dutch Smoker given by the Alumni Association for all guests and their wives—\$2.00 per ticket.

Wednesday, December 4, 1946

9:30 A. M.

Dr. Philip M. Stimson, New York University and Bellvue Hospital—"Recent developments in poliomyelitis."

10:30 A. M.

Dr. William G. Lennox, Harvard, Boston—"Present day diagnosis and treatment of epilepsy."

11:30 A. M.

Dr. Emil Novak, Johns Hopkins and University of Md. Schools of Medicine—"The mechanism and management of functional uterine bleeding."

Clinical Case Presentations

12:30 - 1:00 P. M.

Dr. J. I. Waring—Discussion by Drs. Stimson and Lennox.

1:00 - 1:30 P. M.

Dr. F. G. Cain—Discussion by Dr. Novak.

1:30 P. M.

The Medical College invites all present to luncheon in Medical College Library.

Round Table Discussions

3:00 P. M.

Pediatrics—Drs. Stimson and Lennox.

4:00 P. M.

Gynecology—Dr. Novak

5:00 P. M.

Pathological Conference—pediatric case—Dr. K. M. Lynch, pathology laboratory.

Thursday, December 5, 1946

9:30 A. M.

Dr. Charles A. Doan, Dean Medical School, Ohio State University, Columbus, Ohio—"Exact hemitologic diagnosis and effective specific therapy."

10:30 A. M.

Dr. Hobart A. Reimann, Professor of Medicine, Jefferson Medical College, Philadelphia—"The use and abuse of penicillin and streptomycin."

11:30 A. M.

Dr. William S. Middleton, Dean School of Medicine, University of Wisconsin, Madison, Wis.—"Viral hepatitis."

Clinical Case Presentations

12:30 - 1:00 P. M.

Dr. W. H. Kelley—Discussion by Dr. Reimann.

Round Table Discussions

3:00 P. M.

Infectious Diseases—Dr. Reimann and J. I. Waring.

4:00 P. M.

General Medicine—Drs. Middleton, Doan, and Claude Starr Wright (Teaching Fellow, Ohio State University.)

8:30 P. M.

Founders Day Banquet, Francis Marion Hotel.

Speaker—Dr. Wm. S. Middleton, Madison, Wis.

"The Impact of World War II on British Medicine."

Anyone desiring hotel accommodations should request them through Dr. Horace G. Smithy, Department of Surgery, Medical College, Charleston, S. C., at the earliest possible date.

Dues of the Alumni Association are \$5.00 per year, and along with voluntary contributions should be sent to Dr. Richard Hanckel, Treasurer, 96A Bull St., Charleston, S. C.

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Meeting of Council

October 27, 1946

Columbia Hotel, Columbia, S. C.

The Council met on October 27, at four p.m., in Columbia. MacDonald, Chairman, presided. Present: McLeod, Chapman, Chamberlain, Boyd, Moncrief, Sease, Mayer, Stokes, Thackston, Baker, Meadors and Price. Guest: J. D. Guess of Greenville.

The date of the annual meeting was set as of May 6, 7, 8.

McLeod discussed the plans being made for the annual meeting and outlined the tentative program.

Following a general discussion, it was moved by Mayer and passed that the Association not provide a cocktail hour before the annual banquet.

Guess, Chairman of the Committee on Medical Service Plans, outlined the activities and suggestions of his committee. Following this it was moved and passed that the Committee on Medical Service be instructed to prepare an act for presentation to the General Assembly which would allow the establishment of a medical service plan in South Carolina and that a copy of this proposed act be submitted to each member of Council at least two weeks before it was submitted to the Legislature. The committee was also instructed to work for the passage of the act during the sessions of the Legislature.

Council approved the action of the Treasurer in transferring \$4,500 from the current expense account to the Building and Loan Association of Florence.

It was moved and passed that the Association send a representative to the coming annual Conference on Rural Health and Dr. A. W. Browning of Ellorice was designated as the delegate. It was also suggested that the Executive Committee of the State Board of Health also send a representative.

The Secretary announced the resignation of Dr. C. G. Spivey as Chairman of the Exhibits. The Secretary was instructed to write a letter of thanks to Dr. Spivey for the splendid work which he had done. After discussion it was moved and passed that Mr. M. L. Meadors be placed in charge of the exhibits.

Following a full discussion it was moved and passed that the insurance plan presented by the World Insurance Company be approved as acceptable and that a letter to this effect be sent to Mr. Felix Wheeler, representative of that Company.

Following a lengthy discussion regarding the licensing of hospitals in South Carolina, it was moved and passed that a committee of three be instructed to meet with a similar group from the State Hospital Association for a general discussion of the whole problem. The committee was instructed to attempt to work out some plan which would be mutually agreeable to the State Hospital Association and to our Association and to assist in the preparation of

the necessary legislation for presentation to the General Assembly. The committee, as appointed, consisted of Price, Meadors and MacDonald. The question of the X-ray program in tuberculosis now being carried on throughout the state was fully discussed. A committee composed of Chapman, Baker and Moncrief was instructed to investigate the program and to report its findings.

It was brought out in the discussion that lack of information on the part of Council regarding activities and programs of the State Board of Health tended to create misunderstandings and at times slight friction. A committee composed of McLeod, MacDonald and Mayer, was instructed to meet with the Executive Committee of the State Board of Health for a free discussion aimed toward a better coordination of the activities of the State Board of Health and of the State Medical Association.

There being no further business the meeting was adjourned.

JULIAN P. PRICE,

Secretary.

DR. DICKINSON JOINS A. M. A. STAFF

Frank G. Dickinson, Ph.D., has resigned his position as Associate Professor of Economics at the University of Illinois to accept the position of economist, and director of the Bureau of Medical Economic Research. He succeeds R. G. Leland, M.D., retired, who had served as director of the Bureau of Medical Economics since it was established in 1931.

Except for one year at Pennsylvania State College where he received his A. M. degree, Doctor Dickinson has taught at Illinois since graduation in 1921. He obtained his Ph.D. degree at Illinois in 1927. He served as president of the American Association of University Teachers of Insurance during 1944 and 1945, as its secretary-treasurer from 1932 to 1937, and was one of the joint authors of the preliminary draft of the Illinois Insurance Code in 1934-35. Doctor Dickinson is also a well-known pension and statistical consultant for corporations and is a contributor to scientific and popular journals (e.g. Saturday Evening Post).

Most people probably know him through the Dickinson Football Ratings and the Rockne Memorial Trophy, sponsored by the famous Four Horsemen, which he permanently awarded to the University of Minnesota in 1940.

OUR ADVERTISERS

The following firms have carried advertising with us during 1946. They have helped to make the publication of this Journal possible and we ask that our readers bear this in mind.

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The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

ON SOLVING THE PROBLEM OF HEALTH

The danger of efforts to over-simplify our national health problem is emphasized in an article just released by the Research Council for Economic Security. Based upon a statistical study by Gerhard Hirschfeld, Director of the Council, and Carl W. Strow, his Associate, the statistics appeared originally in the American Sociological Review under the title, "Comparative Health Factors among the States."

The figures are extremely interesting, and while they do not purport to prescribe the solution for the national health problem, their comparison, with reference to several factors in the different states, sheds a new light upon the impracticability of efforts to provide a single cure-all.

About the only thing common to all of the states with respect to the matter of health, is the existence of a problem. That problem varies widely, depending upon many factors—climate, geographical situation, types of inhabitants, financial status and others. For instance, "If the proportion of physicians and hospital beds is two and three times as large in some states as in others, this does not mean that the remedy consists in providing two or three times the number of physicians and hospital beds in underprivileged areas. The medical needs are not necessarily for mere multiplication of numbers."

The article points out that while "Poverty is an entering wedge for illness, kidney trouble strikes the poor less often than it does the rich. The southern states are beset by much illness, yet cancer is less common there. Briefly, there is more to the health problem than the supply of medical care."

The fact that death from disease is by no means always an indication of the extent of medical care available, is illustrated by the authors in this way. Of the nine states with the highest mortality rate from heart disease, seven are in New England. People in these states, on an average, attain a higher age than in any other region. From these facts the conclusion is drawn that "Since heart disease is a disease of old age, this explains why more people die from heart disease in New England than in any other region. Mortality from heart disease in New England is evidence of long life rather than poor health."

The fact that of the ten states leading in mortality as a result of tuberculosis, eight are in the south, must not be considered alone, but in conjunction with the fact that except for "such sanitarium-equipped states as Arizona, Colorado, and Nevada, it will be noted that the leading states have a large

non-white population and a low standard of living." Again it is said, "Cancer mortality is most pronounced among older persons having good incomes and living in cities. It is hardly a coincidence that six of the seven highest states in cancer mortality are in New England. Influenza and pneumonia mortality rates are highest in the south where poverty and poor sanitation are important contributing factors." This study of the distribution of mortality as related to the prevalence of specific diseases, serves to illustrate how the health problems of one locality or age group, or income group, differ from those of others. "If disease is regarded as a national public enemy, it should be noted that it is not like an army massed on open ground, which can be conquered by frontal attack. It is more like an army which has been divided into small guerilla bands, each of which has to be searched out and crushed in turn."

Similar variations are found with respect to the distribution of medical services, hospital facilities, sanitation, housing and other things. In Alabama, Mississippi, and the Carolinas, for instance, the average of physicians is about one to 1400 persons, whereas in California and Massachusetts the proportion is twice as great. Supply of hospital beds vary from one to 600 persons in states like Arkansas, Georgia and Kentucky, to three times that many in Rhode Island, California and Mississippi.

Like variations obtain regarding dental services, nursing and other medical facilities. Those of us in the south should be sufficiently familiar with our sanitation and housing problems to be impressed with the extent of their inadequacy. On the other hand, the housing situation in the large cities may be equally as difficult, but from somewhat different causes.

The writers of the article conclude that "While health is a national problem in the sense that all people are affected by it in one way or another, it is really a combination of layers of regional, local, and individual problems sandwiched together. No matter which of these conditions we undertake to improve, we would waste part of our effort if we blanketed the country with a packaged program."

Again, "Those who advocate some single measure to safeguard national health fail to realize the complexity of the problem."

It is suggested that perhaps the development of methods and facilities in medical care has not kept pace with the development in the industrial and economic phases of life, and with improvement of the living standard generally in respect to other subjects,

"Benzedrine Inhaler appears to eliminate the pain and discomfort which children associate with 'nose drops'... It can be administered with ease even to infants."

Scarano, J. A., and Coppolino, J. F.: Arch. Pediat. 54:97

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Each Benzedrine Inhaler is packed with racemic amphetamine, S. K. F., 250 mg.; menthol, 12.5 mg.; and aromatics.



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through planning and expenditure by county, state and national governments. To illustrate, the past two decades have seen a wonderful expansion and development of our system of public highways, to the extent that now there is scarcely a community where more than a dozen people live which is not adequately served not simply by a state or county road, but by a hard surfaced highway that will accommodate in all types of weather, the automobiles now owned by practically all the families that live in those communities.

There was a time many years ago, when the farmer living thirty miles from the nearest town realized that he could not expect prompt or adequate medical service. His family physician traveled with a horse and buggy and the road that led to the patient's home was such that it would not have accommodated any other type of vehicle if it had been available. These were circumstances which the farmer recognized and accepted as a part of the game when he undertook to make a living and to rear a family on the farm. But today with good roads, good automobiles, modern farm machinery and rural electrification, and with the highest type of scientific medical research and facilities for treatment available in the cities, the farmer feels, and with good reason, that he and his family are entitled to the best that science and the medical profession have to offer.

The Research Council in the same article, points out that efforts are being made to meet the situation, to extend the advantages that medical science has to offer to everyone in need of them. But these efforts, like the problems they are designed to meet, are varied and regulated according to the particular locality, the type of people and the facilities at hand for the problem's solution. Government has made its contribution in the field of sanitation and public health. Private enterprise has done much through the protection afforded employees against illness, accident and other hazards. Through the efforts of hospitals, doctors and public-spirited individuals, means of providing for themselves at a minimum cost has been furnished to millions of others, through the Blue Cross Plans and through the rapidly increasing medical prepayment plans. In this connection, the important thing to be realized is not so much the actual extent of private coverage as the rapid growth throughout the last ten or fifteen years.

And further plans are being perfected. We are quite sure that there has never been a time in this country when so much thought has been given by so many people to, and when such a quantity of material, most of it creditable, has been written on, the problems of health. Plans have been suggested within the last few months which at the time might have seemed far-fetched but which already have proved practicable. To illustrate, one such idea

was for the use of helicopters in those areas inaccessible to the doctor and the ambulance through ordinary means of transportation. Already, since the idea was suggested, we have seen the helicopter used to rescue injured airplane passengers from the wastes of Newfoundland.

A calm and dispassionate study of the statistics and clear reasoning from them, points unwaveringly to the conclusion which has long been recognized by many, that the problem is entirely too complex, that it involves too many different and unrelated factors to be solved by any single overall national plan. The real difficulty, the cause of the failure of the Office of Price Administration to accomplish that for which it was intended, is that so many different factors are involved in the determination of prices and in regulating the manufacture and flow of commodities to market, that it simply is not humanly possible to take all of them into account and make the necessary adjustments all along the line to permit their regulation through artificial controls. The ideal is splendid, but practically it just doesn't work satisfactorily. The same thing will be true of any national system of regulated medical services.

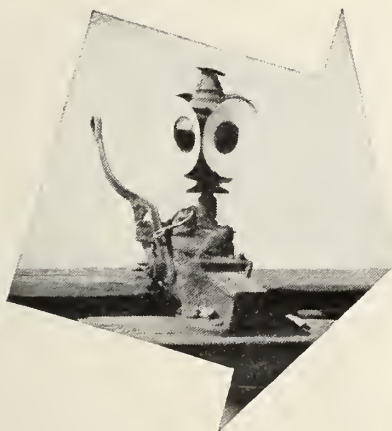
We thought it had always been recognized that the first step in the solution of any vast, complicated problem, is to break it down into its various parts to be dealt with, each in the most appropriate manner. The effort to nationalize medical care, seems to reverse the order of procedure as it endeavors to lump all the little problems which are now being dealt with successfully by separate means, into one vast complicated project, which will present more headaches than the O.P.A., and can never be worked out as a whole.

HOW SOUTH CAROLINA RANKS

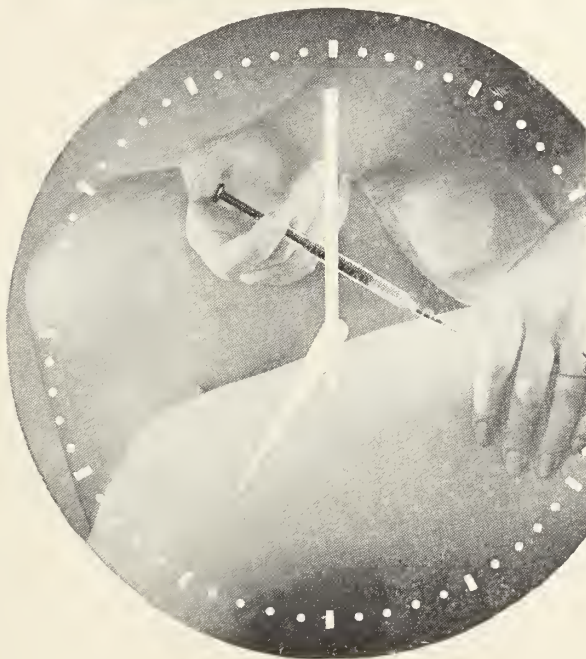
Statistics may be boring, but at the same time, they are frequently enlightening. Figures included in the statistical survey released by the Research Council for Economic Security and referred to elsewhere on this page, show how South Carolina stands in relation to the other states on several counts.

These figures are of interest here because most of them relate to factors which have some bearing upon the health of the people and upon the current issues as to the adequacy of medical service.

It is interesting to note that only one fourth (24.5%) of our total population of 1,899,804 is in the urban areas; that nearly half (43%) are non-white; and that only 13.9% are members of families including three or more children under 10 years. (It is a revealing commentary on modern customs and manner of thinking that families of this size are classified as "large families." What would the statisticians have said of some of the families of our childhood consisting of eight or ten or more?)



a switch in time



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1. THE INITIAL CHANGE-OVER DOSAGE: The first day, 30 minutes or more before breakfast, give a single dose of Globin Insulin, equal to $\frac{1}{2}$ the total previous daily dose of protamine zinc insulin or of protamine zinc insulin combined with regular insulin. The next day, dose may be increased to $\frac{2}{3}$ former total.

2. ADJUSTMENT TO 24-HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

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Most mild and many moderately severe cases may be controlled by *one daily injection* of 'Wellcome' Globin Insulin with Zinc. Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

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Only 4.2% of the people in South Carolina reach an age of more than 65. (Population figures and percentage based on the 1940 census). Just why the percentage of long lives should be less than in many other states is a question that we are not prepared to answer. Undoubtedly this is the result of numerous causes. In this connection, it is interesting to note the comment in the article which accompanied the survey, to the effect that people in New England reach, on an average, a higher age than in any other region. Here, for comparison, are the percentages of persons over 65 in the New England States: Maine, 9.5%; New Hampshire, 9.9%; Vermont, 9.6%; Massachusetts, 8.5%; Rhode Island, 7.5%; Connecticut, 7.6%. The average for all the New England states is more than 4½% above that for South Carolina. We might have thought that the less strenuous life and the greater ease with which a living can be obtained in the south, would have caused the figures to tend in the opposite direction.

Passing from a study of life to that of death, we find that there are 68 deaths of infants under 1 year, per 1000 live births. This compares with a low of 33 in Minnesota and Oregon (both northern states with bitter cold winters) and with a high of 100 (per 1000) in the hot climate of New Mexico. We are impressed with the fact that both Minnesota and Oregon are great farming states with wide rural areas and plenty of "great open spaces." In South Carolina, of every 100,000 of the resident population, there are 190.2 deaths from heart disease; 48 from tuberculosis; and 15.8 from contagious-infectious diseases. The small number of deaths resulting from heart disease as compared with 354.4 (per 100,000 of population) in Connecticut, 362.6 in Maine and 412.9 in Massachusetts, appears to be directly related to the long lives in those areas, since heart disease is primarily a disease of old age and responsible for more deaths in the upper brackets.

The draft rejection figures have been "kicked around" so much in the past few months that most doctors are probably already familiar with them. For ready reference, however, we mention the fact that in South Carolina 43.8% of the registrants from February 1943 to August 1943 were rejected. During the same period, the lowest percentage of rejections was 21.1% in two states, Kansas and Utah, while the only states having a higher proportion than South Carolina, were North Carolina with 45%, and Louisiana and Florida each with 46%.

According to this study, there are 68.7% of the dwelling units in South Carolina without sewer connections, and 22.7% in need of major repairs.

The supply of physicians, according to figures assembled in 1940 and therefore not under wartime conditions, in South Carolina was one for every 1355 of the population. There was one dentist for every 5263 people; a nurse for every 615, and a hospital

bed to every 435 of the population. "Health Expenditures" of the State Government amounted to 99¢ per capita, and health and accident insurance premiums \$1.23 per capita. South Carolina was notable among the states with a blank line to show that we had *no* prepaid medical care plan and *no* Blue Cross Hospitalization Plan. Only two other states could boast this dubious distinction—Idaho and New Mexico, each with a population of a little more than 500,000, about one-fourth that of South Carolina. New Mexico, as we recall, was one of the two last states admitted to the Union. Idaho was not very far ahead of it. South Carolina boasts a distinguished background. One of the stripes on the national flag is hers, as one of the thirteen original colonies. Yet, in the development of voluntary prepayment medical and hospital service organizations, she ranks with some of the most recently admitted among the states.

The figures on our standing as to illiteracy were taken from the 1930 census, and they show 14.9% of the population as being illiterate. Undoubtedly our position has improved since that time, and it is regrettable that more recent figures were not used. According to the records of the U. S. Office of Education, 18.2% of the total school enrollment in 1941 and 1942 were in the secondary grades, (presumably high and junior-high school).

Here, now, are some figures which are indeed interesting, considered in the light of comparison with those relating to other states. In 1941-42 there was an expenditure for school purposes of \$35.57 per child from 5 to 17 years of age in South Carolina. Only Alabama (\$30.52), Arkansas (\$29.17), Georgia (\$33.65), Kentucky (\$35.39), and Mississippi (\$16.15) spent less than we did. There was expended by government units for public recreation according to statistics compiled in 1940-42, 10¢ per capita, but again we were ahead of Mississippi with an expenditure of 3¢, Arkansas, North Dakota and West Virginia with 7¢ and Wyoming 8¢.

Finally, in a general rating of the states on the basis of the factors referred to in the statistics, most of which are mentioned above, South Carolina ranked 45th in the field of educational facilities and recreation; 46th in economic resources; 36th in sanitation; and 42nd in rate of mortality. These ratings certainly do not present our state in a very attractive light. One would think from reading them that we are unhealthy, without culture, lazy, lacking in ambition, and not always as clean as we might be. They will, however, not cause any loss of self-respect by the citizens of this good state, although they should be a source of inspiration to improve our position where improvement is most needed. Furthermore, our report in such detail of the figures here given is not to be construed as indicating any ardent passion for statistics. We think they are useful as indicators, but in that capacity only. They denote trends and general situations. While it is true that

Eye-witness Reports...

IT is one thing to *read* results in a published research. Quite another to see them with your own eyes.

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CASE OF THROAT IRRITATION DUE TO SMOKING
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But may we suggest that you make
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**N. Y. State Journ. Med. 35 No. 11,590
Laryngoscope 1935, XIV, No. 2, 149-154*

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

figures do not lie, the methods by which statistics are obtained, the extent of their completeness, accuracy and the purpose for which they are tabulated have important bearing upon the results indicated. Here however, the sources from which most of the figures were compiled are given, and they appear to be reliable.

The Charlotte Observer of October 12th, for instance, commenting editorially upon the study from which these figures were taken, quoted Thurman Sensing of the Southern States Industrial Council to the effect that Federal Vital Statistics show the South as the section with the lowest death rate, and he raised the pertinent question as to how this can be true if the South ranks at the bottom as to health. The answer, of course, is beyond the scope of our limited knowledge of research. We think it should be referred to the Research Council for Economic Security, and, in fact, we may take the liberty of so referring it.

AN EXPERIMENT FAILS

Nicholas P. Mitchell, who writes a daily column in the Greenville News, has commented more than once recently on the question of state controlled medical care. He wants it clearly understood that he is not to be classified at this time either as an opponent or a proponent of the measures that have been advanced. In his column of October 3rd, he expresses it this way: "Not having the ability to close my mind to the opposing side of a question as readily as some people, I frankly do not know yet just where the correct position is on socialized medicine. I do know that the people of this country are entitled to medical service and hospitalization at rates they can afford to pay."

Mr. Mitchell goes on to say that the tremendous shortage of hospital facilities is the most distressing feature of the situation today, leaving aside the method by which the institutions should be staffed or the expenses paid. In that connection, preliminary work is now being done to remedy the situation, through the survey now in progress under the direction of the Research, Planning and Development Board under the terms of the state statute passed this year, and Public Law 725 (the Hill-Burton Bill).

In the same column, Mr. Mitchell calls attention to failure of one effort on the part of Government to work out a "medical Utopia" on a limited scale. Referring to the Rural Health Service organized a few years ago in Cass County, Texas, under the auspices of the U. S. Department of Agriculture, he quotes Dr. Joe E. Nichols of Atlanta, Texas, to the effect that his County Medical Society was told that the program referred to had no connection with socialized medicine. It seems that assurance was also given that local doctors would help shape the policy of the Health Services and, of course, the clinching argument was "that the provision of greater medical care for the low-income families was a patriotic duty."

The following is Dr. Nichols' view on how the situation has worked out, as quoted in Mr. Mitchell's column:

"We were told that only the low-income farmers would participate. With that understanding, we pledged full cooperation in organizing the experimental group.

"About two months after the organization started a controversy arose which resulted in the dismissal of the advisory committee of doctors. Since then the doctors have had nothing to do with the policy making of the association.

"Both doctors and patients have become disgusted with this form of organization and undoubtedly this is the last year it can operate in Cass County. Fewer than 1,000 members are on the rolls now, and it required a six-weeks advertising campaign to win them.

"The chief reason for the failure has been that the friendly relationship between doctor and patient has almost been destroyed. The average rate for hospitalization is less than \$2.00 a day. A complete physical examination, including laboratory work, nets the doctor about sixty cents, and the members no longer are confined to those in the low-income group. If the citizens of Cass County are permitted to write the final verdict there seems little doubt as to the outcome. Out of 4,500 eligible families, only 845 are participating in the program."

As Mr. Mitchell aptly remarks, "Social planners might study this experiment with profit."

NEWS ITEMS

Announcement has been received of the marriage of Dr. C. Eugene Yeargin of Laurens and Greenville and Miss Jean Bernard Shaw of Boston. Dr. and Mrs. Yeargin are living in Greenville where Dr. Yeargin is practicing pediatrics.

Dr. and Mrs. William C. Cantey of Columbia are receiving congratulations on the arrival of a daughter, Blanche Dennis, on October 5.

Dr. John Scurry (Jack) is now practicing medicine

in Greenwood where he is associated with his father, Dr. C. J. Scurry, and his brother, Dr. Brooks Scurry.

Dr. O. Z. Culler of Orangeburg and Dr. A. E. Baker of Charleston were the guest speakers at the September meeting of the Coastal Medical Society in Walterboro.

Dr. James M. Timmons has recently become associated with his father, Dr. H. L. Timmons of Columbia.

DEPENDABILITY...*the most important quality in a contraceptive*

the extra assurance
with every tube of
Koromex Jelly

**TIME TESTED
CLINICAL
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prescribe...

ACTIVE INGREDIENTS: Boric acid 2.0%, oxyquinolin benzoate 0.02%, and phenylmercuric acetate 0.02% in a base of glycerin, gum tragacanth, gum acacia, perfume and de-ionized water.

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SCIENTIFIC EXHIBIT Centennial Session—American Medical Association

At the Centennial Session of the American Medical Association to be held in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past Century and the latest developments of medical science.

Application blanks for space are now available. All applicants must fill out the regular form. Applications close on January 13, 1947, after which time the Committee on Scientific Exhibit will make its decision and notify the applicants.

Application blanks for space should be procured as soon as possible. They are available from The Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1947 AWARD CONTEST

The National Gastroenterological Association announces its Annual Cash Prize Award Contest for 1947. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at

the Annual Convention Banquet of the National Gastroenterological Association in June of 1947.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, *THE REVIEW OF GASTROENTEROLOGY*. All entries for the 1947 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1947. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

The fifth annual meeting of the American Academy of Dermatology and Syphilology is scheduled for Cleveland, Ohio, from Saturday, December 7 through Thursday, December 12, it is announced by Dr. Earl D. Osborne, secretary of the Academy, 471 Delaware Ave., Buffalo, N. Y. This will be the first meeting of the group since December, 1941, and it is expected to attract more than 1000 members, according to Dr. Osborne.

The principal sessions will be held at the Statler hotel with daily symposia at the Allerton hotel and teaching clinics at Cleveland City hospital Monday, Tuesday, and Wednesday of the convention week. There will be an extensive scientific and commercial exhibit held in connection with the meeting, which will feature special lectures by members of the academy and by famed authorities in such other fields as atomic energy, radiology, and surgery.

PUBLIC HEALTH NEWS

RAPID TREATMENT CENTER CLOSED

Dr. C. L. Guyton, Director, Division of Venereal Disease Control, has announced that the Rapid Treatment Center, located in West Columbia, was closed on Friday, October 11. Hospital equipment and supplies are now being transferred to the former Florence Army Air Field Hospital near Florence. Transfer of equipment and preparation of the hospital for the receiving of patients will require several days.

The capacity of the hospital will be somewhat limited at first, owing to the fact that the hospital's capacity was only 118 beds, and the changes necessary to increase this capacity have not yet been completed. Another cause of delay is that many members of the hospital staff do not wish to move to Florence, and it will be necessary to recruit additional nurses and clerical workers.

Dr. Guyton says full information regarding the opening of the hospital and the allotment of patients to be accepted will be sent to each county prior to the opening date.

101 APPLICATIONS FOR PUBLIC HEALTH FACILITIES APPROVED BY FWA

H. M. McElveen, Special Assistant to the State Health Officer, has announced that 101 applications

for health centers and sewer, water, sanitation and hospital facilities in South Carolina have been approved by the FWA. Included are 87 projects for sewer, water, and sanitation facilities, and 14 projects for hospital facilities and health centers. Total estimated cost of the applications is \$12,273,139. Advance funds already approved total \$357,728.

Recent advance funds approved include:

Orangeburg, \$3,750 for sewer facilities, \$4,200 for water facilities, \$1,667 for storm sewers, \$1,353 for sewerage system.

Lake City, \$2,350 for sewer facilities.

Clinton, \$1,760 for sewer facilities, \$1,387 for sewer facilities.

Pendleton, \$3,515 for sewerage system and treatment plant.

Wagener, \$2,400 for sewerage system.

McCormick, \$3,512 for health facilities.

Branchville, \$5,042 for sewer facilities.

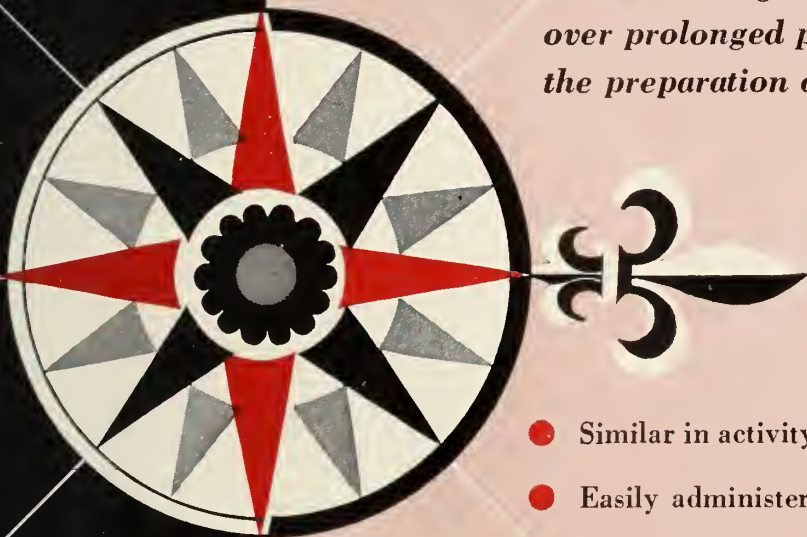
Darlington, \$1,942 for sewer facilities, \$2,657 for sewer facilities.

CAMPAIGN TO COMBAT HEART DISEASE

The initiation of a nationwide program of public education and information on diseases of the heart has been announced by officials of the American

Guiding Principles in Estrogen Therapy

*Because estrogens are usually required
over prolonged periods,
the preparation chosen should be:*



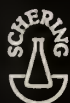
- Similar in activity to nature's own hormone;
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ESTINYL tablets

ESTINYL (ethinyl estradiol), a derivative of the natural follicular hormone, embodies these desirable attributes. In the menopause one tablet of 0.05 mg. daily usually suffices, but two or three tablets may be used daily to control severe symptoms.

ESTINYL Tablets 0.05 mg. (pink) and 0.02 mg. (buff) in bottles of 100, 250 and 1000 tablets.

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Heart Association, Inc.

The program, according to Dr. Howard F. West, of Los Angeles, President of the Association, will have as its prime purpose *"the dissemination of educational information to the public in a broad effort to retard the rapid increase of heart disease throughout the nation."*

"Fatalities ascribed to diseases of the heart," Dr. West said, *"are greater than the total of the next five leading causes of death. It is essential, therefore, that the public know more about the significance of blood pressure, infections, overweight, rheumatic fever, and other factors which contribute to various types of heart disease."*

It is estimated that there are more than 4,000,000 people in the United States today who have heart disease. Diseases of the heart and blood vessels, including cerebral hemorrhage, accounted for 575,000 deaths in 1944. Fatalities from the five other leading causes in 1944 were as follows:

Cancer	171,000
Accidental Deaths	95,000
Nephritis	92,000
Pneumonia	64,000
Tuberculosis	55,000

In addition to accounting for more fatalities than these five causes combined, heart diseases are responsible for an annual loss of more than 100,000,000 work days.

Officials of the American Heart Association state that the Association's program will call for emphasis

on educational work with schools, parent-teachers' associations and other groups concerned with children because of the importance of rheumatic fever and heart disease. According to recent surveys, this scourge of children causes more than five times as many deaths as the combined total of deaths from infantile paralysis, scarlet fever, diphtheria, measles, meningitis, and whooping cough. It is a serious disease among adults, too, as illustrated by the estimated 40,000 veterans who acquired the disease during their recent military service.

The War forcibly dramatized the need for a national health program designed to retard the increase in heart disease cases. An estimated ten per cent of the men rejected by the U. S. Selective Service were disqualified because of cardio-vascular diseases (diseases of the heart and blood vessels). In a survey of a special sampling of 5,000 rejectees for cardio-vascular diseases in five major cities—Chicago, New York, Boston, Philadelphia, San Francisco—50% had been disqualified because of rheumatic heart disease. The second greatest cause of rejection due to cardio-vascular diseases was hypertension (high blood pressure), which accounted for 25.6% of the disqualifications.

The educational campaign of the American Heart Association will reach its climax during National Heart Week to begin on February 9, 1947, which includes St. Valentine's Day. It is expected that all branches of medicine, pharmacy, insurance, industry and many other groups interested in health and public welfare will cooperate fully.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. S. Harry Ross, Anderson, S. C.

Publicity Secretary: Mrs. J. R. Young, Anderson, S. C.

The Spartanburg Medical Auxiliary held their regular meeting at the Cleveland Hotel in August. Following a luncheon Dr. D. Lesesne Smith, Jr., President of the Spartanburg Medical Society, presented a most interesting paper on the Spartanburg County Baby Hospital at Saluda.

The treasurer reported that the Auxiliary's goal of \$5,800 for the Cancer Drive had reached the \$4,200 mark. She also reported that the Jane Todd Memorial Fund had been contributed to generously.

Mrs. Vance W. Brabham entertained the Edisto Medical Auxiliary with a luncheon at her home on Tuesday, September 24th, 1946. The guest of honor was Mrs. Harry Ross of Anderson, State President of the Auxiliary.

Mrs. Brabham's home was artistically decorated for this important first meeting of the Fall. In the living room was an arrangement of pink dahlias, and on the mantel was an exquisite arrangement of pink coral vine and blue morning glories.

Preceding the meeting, members and guests were invited into the dining room where a delicious luncheon was served buffet style. The luncheon

table, with its cream colored damask cloth, its blue Wedgewood china, and a low bowl of pink gladioli and white pom pom chrysanthemum, was lovely. Mrs. H. M. Eargle, president of the Auxiliary, conducted the meeting. She reported that Dr. Hartzog, president of the County Medical Society, had named Dr. C. A. Mobley, Dr. G. M. Truluck and Dr. O. Z. Culler to serve as an Advisory Council for the year.

Mrs. G. M. Truluck urged the members to subscribe to the Bulletin and Hygeia magazine.

Mrs. Vance W. Brabham then introduced the guests of the Auxiliary, Mrs. Harry S. Ross of Anderson, State President of the Auxiliary, Mrs. Emmet Madden of Columbia and Mrs. David F. Adcock of Columbia, President-Elect of the Auxiliary.

Mrs. Ross then gave a talk on the service rendered by doctors' wives in their respective communities on Health Programs. She stated that the aim of the Auxiliary this year was "Service to Others," and that this year, it would be more explicitly Health Education, stressing the point that the place to start with is children. One of this year's aims, too, is a Medical Auxiliary in each of the 46 counties.

At the conclusion of the program, the meeting was adjourned by the president.

South Carolina Medical Association

1946-1947

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W. W. Boyd, M.D.	-----	Spartanburg, S. C.

DEATHS

Simons Ravenel Lucas

Simons Ravenel Lucas, 61, died at the Columbia Hospital on October 5th. He had suffered a heart attack during the closing minutes of the Alabama-Carolina football game and expired a short time after he reached the hospital.

A native of Florence, Dr. Lucas received his education at the University of South Carolina and at the Medical College of the State of S. C. (Class of 1910). Following internship at Roper Hospital Dr. Lucas entered general practice in Florence. Subsequently, he did postgraduate work in New York at the Eye and Ear Infirmary. Returning to Florence he devoted himself to his specialty and later limited his work to ophthalmology. In this latter field he became recognized as one of the leaders in the state. He was a Licentiate of the American Board of Ophthalmology and a Fellow of the American College of Surgeons.

Dr. Lucas was a man who interested himself in civic and church affairs. For ten years he was a member of the Board of Trustees of the University of South Carolina. In his local community he was the Junior Warden of St. John's Episcopal Church, a past president of the Rotary Club and an active participant in philanthropic organizations.

A man of winsome personality, genteel courtesy, and a big heart, he was loved by those who knew him as few physicians are loved. He was a living example of a Christian gentleman.

Dr. Lucas is survived by his widow, Mrs. Natalie Bettis Lucas, two daughters and four grandchildren.

Harry Hammond Griffin

Harry Hammond Griffin, 70, died in Columbia on October 9 following a long illness.

A native of Florence, Dr. Griffin held degrees from Vanderbilt University and from the Medical College of the State of S. C. (1902). For many years he served on the staff of the State Hospital of which his father had been superintendent for fifteen years.

Dr. Griffin is survived by his widow, Mrs. Emily Pinckney Griffin, and two daughters.

Henry Herbert Workman

Henry Herbert Workman died on October 10. He had been in declining health for a long time and critically ill for ten days.

A native of Woodruff, Dr. Workman attended Furman University and was graduated from the Medical College of the State of S. C. (1905). For forty-one years he engaged in general practice at Woodruff. He was prominent in the work of the Baptist Church and was an active Mason.

Dr. Workman is survived by his widow, Mrs. Carrie Rogers Workman, two sons, Henry H. Workman, Jr. and Dr. John Anderson Workman. One of his brothers, Dr. B. J. Workman, is a surgeon in Woodruff.

Edward Clayton Stroud

Edward Clayton Stroud, 71, an Honorary Member of the S. C. Medical Association, died on October 2.

A native of Greenville County, Dr. Stroud was a graduate of the University of the South Medical Department (Sewanee) (1899). For forty-six years he practiced medicine for the people of Marietta

and the surrounding community.

Dr. Stroud is survived by his widow, Mrs. Daisy Good Stroud, two sons and one daughter.

Caleb Wooster Harris

Caleb Wooster Harris, 75, died at his home in Bishopville after an illness of several months.

A native of Darlington County, Dr. Harris received his medical education at Vanderbilt University (1894). In 1897 he located in Bishopville where he carried on a general practice up to the time of his last illness.

Dr. Harris is survived by three daughters.

BOOK REVIEWS

PRACTICAL MALARIOLOGY

(Prepared under the auspices of the Division of Medical Sciences of the National Research Council.)

By

PAUL F. RUSSELL, M.D.

LUTHER S. WEST, Ph.D.

REGINALD D. MANWELL, D.Sc.

Evaluation of this book depends entirely on whether one regards malaria from the "large view" of its international importance, or from the standpoint of the individual practitioner with his localized malarial problems. The reviewer admits his incompetence to criticize the book from the vantage-point of the peripatetic and cosmopolitan malarial epidemiologist.

The wealth of information and practical experience of the authors is demonstrated in the minutiae of detail incorporated in this 700-page manual. Therein lies the fault of the book from the practitioner's view. He will find himself submerged in a maze of detailed technical description in trying to find the answer to his individual problems. The technical aspects of the book may be illustrated by the devotion of 70 pages to "Morphology, Taxonomy, and Life Cycle," while human "Pathology, Clinical Aspects, and Treatment" is completed in 51 pages.

The title is misleading unless it be qualified to state that it implies "practical" for the specialist in malarial control, for whom I assume the book was primarily written. The book thoroughly fills a need for a concise reference-text for those engaged in the laboratory and field branches of malaria control. It is a technical manual.

Illustrations are very good, though a number are of more snap-shot value than scientific. Tabling is well-done. The five pages of color-plates of malaria hematology add little to the attempts of others to project microscopic pictures onto paper.

The section on "Laboratory and Field Technique" contains some practical advances. Suffice it to say that progress in parasite cultivation and serology are still far from the stage where it affords any hope of incorporation in the office or small laboratory.

Chapters on "Epidemiology," "Climatology," and "Malarial Surveys" are interesting and informative. The material on chemotherapeutic prophylaxis was brief and disappointing.

It is well-indexed. The appendix of almost 100 pages is doubtless a comprehensive and complete contribution to entomology.

In general the book is readable, complete, compiling old and new information in well-written form, but it is not a quick-reference book for the average doctor's book-case.

J. M. A.

The Journal of the South Carolina Medical Association

DECEMBER, 1946

VOL. XLII, NO. 12



Article	Author	Page
The Treatment of Hemothorax and Its Complications in Thoracic Injuries	Edward F. Parker, M.D., and Thomas H. Burford, M.D.	325
Post Hoc Sed Non Propter Hoc	R. M. Pollitzer, M.D.	330
Obesity in General Practice	Wm. T. Hendrix, M.D.	332
Editorials — The Ten Point Program — Public Health News — Woman's Auxiliary News Items — Deaths		

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FINE PHARMACEUTICALS SINCE 1886

U P J O H N V I T A M I N S

OFFICE OF PUBLICATION: 105 WEST CHEVES STREET, FLORENCE, SOUTH CAROLINA

Entered as second-class matter February 9, 1916, at the post office at Greenville, South Carolina, under Act of Mar. 3, 1879
Accepted for mailing at special rate of postage provided for in Sec. 1103 Act of October 3, 1917, authorized Aug. 2, 1918

THE JOURNAL

of the

South Carolina Medical Association

VOLUME XLII

December, 1946

NUMBER 12

The Treatment of Hemothorax and Its Complications in Thoracic Injuries*

by

EDWARD F. PARKER, M. D., Charleston, S. C.

and

THOMAS H. BURFORD, M. D., St. Louis, Mo.

Because of the frequency of automobile accidents and yet other hazards of present day life, the treatment of hemothorax accompanying wounds and injuries of the thorax can be no less important in peace than in war. Further, it may be stated that the lessons learned and the knowledge gained in the treatment of hemothorax in World War II, are definitely applicable to the treatment of those cases occurring in civil practice.

Whereas before the War, the object of therapy, in most centers, was largely the prevention of empyema, such a conservative attitude is no longer tenable. Further, in cases in whom the complications of persistent clotting and of empyema occur, non-operative therapy in the former, and prolonged drainage in the latter, can be considered no longer adequate therapy in many cases. Rather, the object of therapy in all cases of hemothorax must be the restoration of the function of the secondarily collapsed lung as rapidly as possible.¹ This is equally true even in the uncomplicated cases of hemothorax, without persistent clotting or empyema. The means whereby the above may be accomplished in a gratifyingly high percentage of the cases are several, and shall be considered in the discussion of the treatment of hemothorax in its several pathological states.

The foregoing remarks are based upon the study of 870 cases of an intrathoracic wound observed in the Mediterranean Theater during a consecutive nine-month period in 1944.^{2 3 4} Excluded from the study were the thoracic wall wounds, which were no different from soft tissue wounds of other parts of the body.

Hemothorax was the most serious concomitant of

intra-thoracic wounds. Its occurrence was noted in 752 or 86.4% of the cases, thereby making it the most frequent concomitant also.

Without going into a discussion of the occurrence of initial clotting of blood in the pleural cavity and subsequent liquefaction,⁵ and the cause or causes of delayed clotting, for clinical purposes, cases of hemothorax of traumatic origin may be classified readily into four different groups:

1. Liquid hemothorax without empyema.
2. Liquid hemothorax with empyema.
3. Clotted hemothorax without empyema.
4. Clotted hemothorax with empyema.

The rationale of the treatment of the different clinical types is based upon the pathology, which will be described briefly.

Whether it is due to defibrination of the hemothorax by the rapid motion of the heart and lungs, or whether due to fibrinous exudation resulting from inflammation of the pleura because of the presence of blood, virtually all cases of hemothorax are associated with a deposition of fibrin on the pleural surfaces in contact with the blood.

In a liquid hemothorax without empyema, fortunately the amount of fibrin on the pleural surfaces is not great. It is usually present only in patches, and does not form in a continuous sheet, as observed in the other types. Because of this patchy distribution, there is no hindrance to expansion of the lung after removal of the blood. The amount of expansion obtainable in most cases is determined only by the amount of blood removed.

In a clotted hemothorax without empyema, the amount of fibrin on the pleural surfaces is far greater. Further, it forms in a continuous sheet. The sheet varies from 3 to 10 mm. in thickness. As the sheet of fibrin is continuous at the sites of reflection from the visceral onto the parietal pleura, the clotted

*From the Departments of Surgery, Medical College of South Carolina and Washington University.

(Read at Annual Session, Myrtle Beach, May 1, 1946.)

hemothorax becomes encapsulated. If the size of the clot is larger than that which can be absorbed very rapidly, organization of the layer of fibrin on the pleural surfaces begins early. The organization begins in that portion of the layer of fibrin immediately adjacent to the pleurae, while the free surface of the layer abutting on the hemothorax remains fibrinous. As the process continues, the fibrosis may increase until the entire sheet is involved, after which the sheet, or "peel," may become fused with pleurae.

When empyema develops in a liquid or clotted hemothorax, it becomes encapsulated in the manner described in the preceding paragraph. Likewise, organization of the originally fibrinous capsule takes place in a similar manner. In fact, the processes are the same except in two particulars. In empyema, that part of the capsule abutting on the infected hemothorax is fibrino-purulent in character instead of being solely fibrinous. And secondly, in empyema, the organization of the capsule takes place more rapidly.

In addition, in a clotted hemothorax with and without empyema, the clot is frequently divided into locules by fibrinous septa traversing it. Therefore on thoracentesis in such cases, one may be able to withdraw nothing at one site, whereas at another there may be withdrawn a few clot fragments, a small amount of dark thick blood representing liquefied clot, or a small amount of pus. And in the case of empyema in a clotted hemothorax, it may not be possible to withdraw pus, because of failure to have entered a locule in which actual suppurative liquefaction of an infected clot has taken place.

From a therapeutic standpoint there are four most significant facts regarding the pathology. First, in the early stages of the encapsulation of the blood or pus in the pleural cavity, there exists a line of cleavage between the capsule and the pleura. In the average case, obliteration of the line of cleavage, by progression of the fibrosis to involve the pleura, does not occur until about 90 to 100 days after the onset of the process. Second, that portion of the organizing fibrinous capsule which overlays the visceral pleura definitely retards or prevents expansion of the lung. Unless resolution of the inflammatory changes in the capsule occurs spontaneously or can be induced by proper treatment, or unless the visceral portion of the capsule is removed, ultimately the lung may be imprisoned beneath it in total or partial permanent collapse. Third, until the process becomes so extensive that the visceral pleura is involved in the fibrosis, the visceral pleura remains grossly normal, and does not become "thickened." The fourth concerns the lung. It is capable of withstanding extensive contusion, laceration, or hematoma formation, and of returning to normal rapidly. In particular, there is a rapid return of normal expansibility, in the absence of which, decortication would be ineffective. The importance of the above four observations cannot be overestimated.

In the treatment of a liquid hemothorax without empyema, we believe in repeated aspirations begun early, and continued at daily intervals until the pleural cavity is empty and remains so. The reasons for this are four:

1. To remove the culture medium.
2. To obliterate the dead space.
3. To re-expand and restore the function of the lung.
4. To lessen the chance of delayed clotting.

The first two are factors concerned in the possible development of empyema. Their importance cannot be questioned. In this regard, the air replacement method of therapy is considered highly undesirable, because it merely substitutes one type of dead space for another. The persistence of any dead space enhances the chances of the development of empyema. If empyema does follow, early frequent aspirations will reduce the size of the hemothoracic space to become involved.

Re-expansion of the lung to increase the vital capacity, apart from being an emergency procedure at times, is desirable in all cases. The feeling of well-being and the ability to breathe deeper is improved, the effectiveness of any cough is greatly enhanced, and its duration thereby shortened.

By beginning thoracenteses early for eradication of the hemothorax, we mean on the day of its onset, or even immediately after its occurrence. In fact, at times the latter is a necessity in the pre-operative care to relieve marked dyspnoea, in order to allow an indicated operation for some associated intrathoracic complication. In former years, the chief objection to early aspiration of a hemothorax has been the fear of precipitating further hemorrhage from a laceration in the lung by its expansion. Actually, because of the low arterial pressure in the pulmonary circuit, hemorrhage from a laceration of the lung is of short duration in the vast majority of cases. This has been verified at operation in such cases by many observers. Further, in our series of 752 cases of hemothorax, treated by early aspiration, there were only 3 cases (0.4%) of secondary hemorrhage. In two of these cases of secondary hemorrhage, it was later proved that it came from a laceration of vessels in the thoracic wall (intercostal artery and subclavian artery). In the third case, the hemorrhage did arise from the lung, but re-expansion of the lung was not a factor, because the initial hemothorax was clotted, and thoracenteses were unsuccessful.

Among the 752 cases of hemothorax, the liquid without empyema type comprised 80.2% (602 cases). (Table I). Their treatment by frequent aspirations begun early resulted in far less morbidity than would have been the case had not such a vigorous regime been adopted. In this group, the hemothorax per se

was not the cause of failure to return a man to duty in a single instance.

The remaining cases were composed of 75 cases (10%) of liquid hemothorax with empyema, 44 cases (5.8%) of clotted hemothorax without empyema, and 30 cases (4.0%) of clotted hemothorax with empyema. Thus, the total incidence of clotting was

Table I

The Incidence of the Four Types of Hemothorax Among 752 Cases of An Intrathoracic Wound Thus Complicated

	No. of	
	Cases	%
Liquid Hemothorax without Empyema	603	80.2
Liquid Hemothorax with Empyema	75	10.0
Clotted Hemothorax without Empyema	44	5.8
Clotted Hemothorax with Empyema	30	4.0

9.8%, virtually 1 of every 10 cases. The total incidence of empyema was 14% in the hemothoracic cases (12% in the entire group of intrathoracic wounds). And considering only the liquid without empyema type as being uncomplicated hemothorax, the total incidence of complicated hemothorax was 19.8%, virtually 1 of every 5 cases. (Table I).

The treatment of clotted hemothorax without empyema depends upon its size, and if large, upon the progress towards resolution in the first four to six weeks following its onset.

If it is small, conservative therapy is indicated with an occasional thoracentesis to remove any clot that might have liquefied, and to verify the continued absence of suppuration. In those of our cases so treated, the average time required for resolution and therefore complete expansion and full return of pulmonary function, was 78 days.

If the clotted hemothorax is massive, that is produces a 50% or greater degree of collapse of the lung, careful observation and weekly roentgenographic examinations are necessary. Even when massive, about two-thirds of these cases will resolve spontaneously. However, if massive, and if not diminishing in size, the treatment of choice is decortication of the lung. If this is not performed, recovery is unduly prolonged, and chronic hydrothorax,⁵ fibrothorax, or calcareothorax might result. The optimum time for operation is between 3 to 6 weeks after the onset of the hemothorax. The technique of operation has been described elsewhere.²

An additional indication for decortication of the lung in clotted hemothorax regardless of its size, may be another intrathoracic complication, such as a foreign body in the lung or pleural cavity requiring removal. In such cases, after evacuating the hemothorax, the lung must be decorticated and full pulmonary expansion obtained in order to prevent the persistence of dead space post-operatively, and thereby lessen the likelihood of post-operative empyema.

In 20 of our cases of massive clotted hemothorax without empyema treated by decortication, whether operated upon for the hemothorax alone or an associated foreign body, there was no recurrence of the hemothorax in any. The sole significant complication was a transient broncho-pleural fistula in one case. There were no post-operative wound infections, empyemata, or deaths.

Despite the advances in chemotherapy, empyema remains a complication of intrathoracic wounds. While during the early phases of the War, its incidence was 22.6%, only a little less than the incidence in World War I, it is gratifying to report that its incidence in the Mediterranean Theater was reduced to 7% in the final phase of the War in the spring of 1945. Chemotherapy, specifically the use of penicillin, while only one of many factors responsible for this significant reduction, was nevertheless an important one. Other factors of paramount importance included the advances made in pre-operative therapy; those in initial surgical therapy, including the establishment of definite indications for major thoracotomy or for debridement of the thoracic wall alone; the sharpening judgment and the increasing operative skill of the forward surgeons; the evolution of the optimum plan for the treatment of intrathoracic foreign bodies; and the recognition of the urgent need for the obliteration of all pleural dead space whether due to hemothorax or pneumothorax or both, as rapidly as possible.¹

As improvement in the empyema incidence rate occurred, so did there develop advances in its treatment. Chief among these was the use of early decortication of the lung in selected acute cases, with and without preliminary drainage.

From the standpoint of treatment, cases with acute empyema may be classified conveniently into four general groups:

1. Those with small cavities, most frequently basal in location.
2. Those with cavities of massive size, in whom there is no contraindication to a major thoracotomy for decortication of the lung as the initial operation.
3. Those also with cavities of massive size, in whom a major thoracotomy is contraindicated, and who are therefore treated by rib resection drainage, with satisfactory pulmonary expansion and cavity obliteration following.
4. Those cases similar to the previous class, except that satisfactory pulmonary expansion does not follow.

If the empyema cavity is small and especially when only basal in location, the treatment should be adequate drainage by the conventional rib-resection technique. We do not believe that the so-called aspiration treatment or the intercostal catheter drainage constitute adequate drainage. The local use of penicillin in the empyema cavity may be tried for a brief period of time, but in our experience it has

been rare that the need for external drainage, after true pus has formed, has been obviated by its use. Fortunately, most cases of empyema are small and basal. In 60 of 65 of our cases of this type, the results of rib resection drainage were satisfactory. We do not classify the results in this group in more detail, because we did not keep the patients under observation until they were well. Instead, because of the usual lengthy duration of suppuration, all of the 60 cases were returned to the States for further care and treatment, but only after it appeared that no further operation for drainage or chronicity would become necessary. In this group, there were 5 deaths. Two were due to an overwhelming pleural infection secondary to an esophago-pleural fistula. The other three were due primarily to severe associated extrathoracic wounds. There was no case of empyema in whom death could be attributed to the lack of adequate drainage, or to premature drainage.

If the empyema is massive in size, the treatment of choice is early pulmonary decortication as soon as the diagnosis is made, provided there is no contraindication. Excluding extrathoracic contraindications, the sole criterion remaining is the severity of the systemic response to the acute infection. In evaluating this, more important than the degree of fever manifested is the general appearance, alertness, appetite, and response to transfusions, of the patient. If the latter observations are favorable, decortication may be performed, with penicillin therapy pre- and post-operatively, even though the fever may reach 102.0° or 103.0° each day. At operation, not only are the contents of the pleural cavity evacuated, but the visceral portion of the capsule or "peel" is removed from the lung to allow its immediate and completely normal expansion to fill the entire hemithorax, and thereby obliterate all pleural dead space. Postoperatively, there must be adequate closed drainage at multiple sites to maintain the complete expansion.² If any dead space persists, naturally the empyema will likely recur.

In our series, there were 22 cases of acute massive empyema treated by early pulmonary decortication without preliminary drainage (primary decortication). The empyema developed in a clotted hemothorax in 18 cases, and in a liquid hemothorax in 4 cases. Prompt cure was obtained in 18 (82%) of the 22 cases, in that there was no clinical or roentgenographic evidence of persistence or recurrence of the empyema within two weeks following operation. The cure was dramatic. In 4 (18%) of the 22 cases, the empyema recurred. In 3 of the 4, though cure did not result, the patients were markedly improved, in that the recurrent cavities were small, and after rib resection drainage of these, their rapid obliteration was taking place while under our observation. In 1 case (4.5%), death occurred one month after operation, because of a persisting empyema due to *B. coli*, the severity of which was uninfluenced by any available chemotherapeutic agent.

There were 4 cases with massive-sized cavities in whom primary decortication would have been the treatment of choice, but who were treated by rib resection drainage because of some contraindication to the former. Satisfactory pulmonary expansion followed rapidly, thus obviating the need for subsequent operation. But these 4 cases should be contrasted with the 9 cases in the group below. By this contrast, it is apparent that only one-third of the 13 cases with originally massive-sized acute empyema cavities progressed sufficiently satisfactorily after rib resection drainage, so that chronic empyema did not appear imminent.

There were 9 cases of acute empyema with cavities of massive size, treated first by rib resection drainage because of some contraindication to primary decortication. In these 9 cases, satisfactory cavity obliteration by pulmonary expansion failed to follow in the succeeding four to six weeks.

In such cases as the above, secondary decortication (operation in the presence of adequate drainage) is definitely the treatment of choice. The purposes are to prevent chronicity, and to reduce or render negligible the time required to obliterate the pleural cavity and therefore terminate the pleural suppuration.

In 1 of the 9 cases, further operation to prevent chronicity was not performed because of an exceedingly poor prognosis in the presence of an associated laceration of the dorsal spinal cord with paraplegia. In 2 of the 9 cases, exploratory thoracotomy was performed in order to decorticate the lung, but this was found impossible because the pathological process was already chronic. The capsule and the pleura were completely fused.

In the remaining 6 of the 9 cases, pulmonary decortication was performed successfully. In 2 of the 6 cases, prompt cure followed, according to the previously stated criteria. While 4 cases developed recurrent empyema, 2 of the cases were markedly improved, as the recurrent cavities were small and basilar. They were considered not only salvaged from chronicity, but also the estimated duration of pleural suppuration was considered to have been markedly reduced. Unfortunately, in the remaining 2 cases, significant improvement did not occur, and further operation for chronicity was deemed most likely to become necessary after their return to the States.

Thus in the 6 cases having secondary decortication, 2 cases (33.3%) were cured, 2 cases (33.3%) were markedly improved (a total of 66.6% salvaged from probable chronicity), and 2 cases (33.3%) were unimproved.

Comparing the results obtained by primary decortication and secondary decortication, those by the primary were far better. This is explainable on the basis of the fact that in the cases treated by secondary decortication, the pathological process was of a much

longer duration. The average time interval between wounding and primary decortication was 20 days, while the average time interval between wounding and secondary decortication was 53 days. Also those cases treated by secondary decortication represented the more seriously ill group.

Excluded from the analysis were 5 cases of empyema treated elsewhere, and who came under our observation only during their convalescence.

Summary

1. Hemothorax is the most frequent and serious concomitant of intrathoracic wounds and injuries.

2. For clinical purposes, hemothorax may be classified into four groups, namely liquid and clotted, each with and without empyema.

3. The pathology is described, and the rationale of the treatment advocated is based thereon. The object of therapy in all cases must be the restoration of the anatomical and physiological normalcy of the secondarily collapsed lung as rapidly as possible.

4. Liquid hemothorax without empyema, regardless of size, should be treated by repeated aspirations begun early and continued at frequent intervals until the pleural cavity is empty.

5. Persisting massive clotted hemothorax without empyema should be treated by decortication of the lung.

6. Massive empyema, whether in a liquid or clotted hemothorax, should be treated by early primary decortication of the lung when possible.

7. Massive empyema which persists after adequate rib resection drainage, should be treated by early secondary decortication of the lung.

8. The results obtained in a large series of cases are cited in support of the above contentions.

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DISCUSSION

By DR. WILLIAM H. PRIOLEAU
Charleston, S. C.

It has taken the last war to clarify our ideas about the treatment of hemothorax and resultant empyema. Up to the present we have not recognized the importance of keeping the pleural cavity empty so as to prevent complications. Heretofore we have been inclined to leave well enough alone and to aspirate fluid, blood, and gas only in case of pressure, infection, or failure of absorption. It has now been amply demonstrated that the safest course is to make early and continued efforts to keep the pleural cavity empty, if we are to prevent disabling complications. In this connection I would like to emphasize Dr. Parker's admonition against the injection of air for partial replacement of the fluid aspirated. First, it is not necessary. Secondly, the air rises and in so doing breaks down any tendency toward walling off with resultant possible spread of contamination and development of a more extensive empyema.

As a result of the work of Dr. Parker's and other groups in thoracic surgery, the treatment of clotted hemothorax and empyema has been revolutionized. Relatively early decortication of the imprisoned lung has resulted in its expansion with accompanying obliteration of the pleural space. Such a procedure, generally saves the patients from a long illness, deformity of the thoracic cage and loss of much lung tissue.

Post Hoc Sed Non Propter Hoc*

R. M. POLLITZER, M. D.
Greenville, S. C.

Man is supposed to be a reasoning animal. That is, he has been given a brain which is capable of taking certain facts, considering them and coming to a conclusion. Because of this he has been labeled by biologists, *Homo sapiens*.† Although capable of reasoning, his reasoning often is imperfect or illogical, and at times, there is even an absence of reasoning and man acts purely from impulse. Some writers have wondered whether man should not be called *Homo insanicus*.‡

Barring rare exceptions, all babies at some time during the first year of life have one or more teeth which push through the gums and become visible to the fond parents, who view this historic event with great excitement. Usually when the infant is two or three months old, the mother announces with much pride that the baby is cutting a tooth. At this time the infant does have some swelling of the gum and an increase in saliva; but as a rule, the tooth cannot be seen or felt for three or four months yet. Not infrequently, after having looked for the tooth daily for weeks or months, it suddenly makes its appearance and is found accidentally, without there having been fever, convulsions, paralysis or any other pathological manifestation. This is nearly always the rule.

Let us see what generally happens in most families. At three months, six months, or almost anytime during the first two years, the youngster is fretful, has fever, an eruption, or a convulsion. In other words, the baby is sick. Everyone is naturally very much perturbed. The grandmother and aunt, the mother or friend looks in the mouth and sees one or more places in the gum markedly swollen where a tooth is attempting to erupt. Or sure enough the baby has "cut a tooth." Immediately the would-be diagnostician concludes that since a tooth is coming, or has just come, the baby has been made ill by "teething." The reasoning is fallacious. This is an example of one of the commonest of all fallacies in reasoning. It goes like this: if the baby is cutting, or has cut a tooth recently and now is ill, since the illness preceded the teething, the teething must have produced the illness. One might just as well conclude that the change of the moon produced a convulsion or a paralysis. Logicians have coined a name for this type of fallacy, "Post hoc, ergo propter hoc." Translated literally into English, this is rendered "following this," therefore, "because of this." We all know that even if something succeeds something else, it does not necessarily mean that the phenomenon was produced by that particular occurrence.

Not so very long ago people believed implicitly that most ills were sent by the devil, or that those

afflicted with bodily ills, and the insane were possessed of the devil or bewitched. Witchcraft has now died out; and few people blame their earthly misfortunes on the devil. But even now a small number of men and women hold to the belief that all their misfortunes are sent as punishment from the Lord.

However, today, in the United States of America, most people have had some education, or at least have spent a few years in school. They are supposed to have some slight amount of understanding of natural science. And most of them have heard that diseases are brought about by definite causes. They admit that Measles, Whooping Cough, Typhoid Fever, Diphtheria, etc. are diseases caused by a germ.

But quite naturally when a baby in the family becomes ill, they are unwilling to admit that he has an illness of consequence and try to delude themselves into thinking that his indisposition is a normal manifestation. Regardless of whether the baby vomits, has diarrhea or fever, they are confident that the malady is to be expected because the baby is "teething," and they know he is teething because the gum is swollen or a tooth has just come through.

Of course there is some fretfulness, discomfort or pain when a tooth erupts, and along with this, some increase in the flow of saliva. At times there is a disinclination to take food. Further, all adults well know how much discomfort the eruption of the wisdom teeth can cause. But admitting all this, medical authorities insist that it is extremely unlikely that the eruption of teeth can cause illness. The views of three outstanding pediatricians are presented in the following four paragraphs:

"From a very early period the view has descended that a large number of symptoms occurring between the ages of six months and two years are due to difficult dentition. The list of such symptoms is a long one, but year by year it has been progressively shortened as one after another has been shown to depend upon other causes, dentition being only a coincidence.

"At the present time many good observers deny that dentition is ever a cause of symptoms in children, some even going so far as to say that the growth of the teeth causes no more symptoms than the growth of the hair."¹

"Teething may be associated with a certain amount of discomfort, such as swollen, tender gums and consequent restlessness and loss of appetite, but still be quite within the normal limits. Very seldom is there any illness due directly or indirectly to the eruption of the teeth, and all other possible causes

must be ruled out before the illness is laid at the door of teething."²

"In the early part of this century a great number of disorders (fever, convulsions, diarrhea, croup) were often mistakenly attributed to dentitional difficulties. Even today, undiagnosed fevers in early childhood are frequently attributed to teething. There is little basis for the view that the eruption of the tooth causes the fever. The only association between fever and the eruption of teeth is the fact that during a fever the rate of eruption of a given tooth is accelerated."³

We doctors, especially those of us who practice pediatrics, believe that a diagnosis of teething is unjustifiable, even though we know that the baby is getting teeth during the first two years. We are not surprised when mama or grandmama says, "Doctor, the baby is teething." They are not expected to know pediatrics. They are not expected to make a physical examination. But it is surprising when an infant is referred by another doctor because of teething, or when we are told that some other doctor has made a diagnosis of teething, especially so when this is done without a history having been obtained, or a physical examination having been made. Tonsillitis, Pyelo-nephritis, Otitis Media, Pneumonia, Infectious Diarrhea and many other diseases are overlooked because it is so easy to label the malady "teething." And furthermore, since this diagnosis agrees with that of the mother, everyone is happy. Nevertheless because the true nature of the baby's illness has not been ascertained, no benefit accrues to him or her, and the disease runs its course resulting in death or recovery, according to the youngster's resistance.

It would be very interesting if every doctor who

treats babies kept a record throughout the year of the number of patients on whom he makes a diagnosis of teething. This should be followed with a note as to what the outcome was, and especially what was the final diagnosis. In short we still hear too much of teething.

The doctors who were practicing about a century ago knew little of pediatrics and were forced to make a diagnosis of teething. But today, especially since medical science has made such tremendous strides, particularly in the last 50 or 60 years, there is little excuse for blaming most illnesses in the child on the cutting of teeth. As a rule a complete history, a careful physical examination and a few laboratory procedures will relieve the practitioner of the necessity for covering up his ignorance by making a diagnosis of teething.

*Following this, but not because of this.

†Wise man.

‡Crazy man.

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Obesity in General Practice

By WM. T. HENDRIX, M. D.
Spartanburg, S. C.

This is a report on two hundred cases of successful reduction of weight. It is not a complete series with percentages of success and failure such as an internist would report. I do not have the time, training, or office force to run such a series.

It started as a family doctor's attempt to help his patients lose weight. Thyroid and pituitary gland changes will not be reviewed. I would not deny, of course, that there are cases of glandular disturbance, as I have seen attractive pictures in medical books of hypothyroidism, Frohlich's syndrome, and basophylic pituitary something or other. We stay so confused trying to remember which gland is involved when you have little wrists and large hips, or when the line from the navel to the head is longer than from the scrotum to the floor, that we miss the main point—that 99 out of 100 obese patients just plain eat wrong. We should worry more about the size of the diet than the size of the genitalia. If as much time were spent explaining diet to a patient and giving moral support to follow it as is spent in B.M.R. tests and measurements, more people would lose weight.

There are benefits to doctor and to patient in weight reduction:

DOCTORS:

1. No patient will sing your praises more than one who loses weight, and no patient attracts more attention and is in a better position to refer patients than a young, fat girl who loses 75 pounds. One girl in Glendale, one in Whitney and two in Spartanburg are the nucleus from which all of these 200 cases have been sent in. At least 2 or 3 patients a week come in "to get that medicine you gave Mary Jones."

2. It gives a form of treatment to those people with foot or back trouble, shortness of breath, and that tired feeling due to overweight—the type case we usually hate to see come to the office.

PATIENTS:

1. Without exception, all of my patients who lost 10 pounds or more have felt better. They are able to get around and do more work. This improvement, coupled with a feeling of well-being given by the benzedrine sulphate greatly improves their morale. As you know, psychiatrists claim most fat people have some emotional disturbance in the background;

they hide behind their weight to cover unpopularity, unhappiness, etc. At any rate, fat people get into a vicious circle—the fatter they get, the worse they feel, the less active they become and *the fatter they get*. One of the first patients in this group had been delivered of a still-born three years before. She lost interest, put on forty pounds, had to quit her job in the mill due to hysterical fits and crying spells. This patient under treatment lost from 178 pounds to 130 pounds, took on new interest and activities and is today working, happy and healthy.

2. Better health—Improved physical findings. In a majority of people thirty pounds or more overweight, we found increased blood pressure and pulse rate, both of which were reduced with weight loss.

REPRESENTATIVE CASES:

	Age	Date	Weight	B. P.	Pulse
A.	59	8/22/44	176	154/70	120
		9/27/44	160	130/80	92
		10/27/44	152	128/70	82
		4/4/45	141	134/80	72
B.	44	1/26/45	275	210/130	96
		2/26/45	258	176/120	80
		3/26/45	247	154/100	84
		5/18/45	227	140/90	100
		11/6/45	184	130/100	100

This patient complained of vertigo, tinitis, dyspnea; symptoms relieved.

C.	52	4/20/45	150	140/80	72
		5/2/45	145	126/70	80
		5/26/45	141	120/60	80
D.	39	8/25/44	237	178/100	100
		10/2/44	228	150/90	88
		11/4/44	215	140/100	76
		3/31/45	182	140/100	76

This patient stated she was too nervous to lose weight as she couldn't take thyroid, but she lost nicely on benzedrine sulphate.

E.	32	2/12/45	278	150/90	84
		3/13/45	262	130/80	72
		6/23/45	231	166/60	72
		9/25/45	222	110/70	72
		12/1/45	226		

This patient had no menses; weighed 115 lbs. when married; had five children. She did not use prevention and had had no pregnancy in eight years. She had menses for 2 months and is now 2 months pregnant after none in eight years; she is very unhappy about pregnancy.

(From the Department of Medicine, Spartanburg General Hospital.)

F.	33	8/27/45	191	150/100	88
		9/12/45	181	138/80	88
		10/23/45	164	130/80	100
		1/26/46	151½	130/70	60

At beginning of treatment patient was very nervous.

3. Hypertensive; cardio-vascular disease—Blood pressure did not improve, but the patients felt better.

	Age	Date	Weight	B. P.	Pulse
A.	48	2/1/44	180	166/100	80
		4/14/44	155	174/104	72
		8/11/44	142	153/90	72
		12/11/44	140	170/100	80
		7/10/45	141	164/100	88
		3/8/46	141	170/100	88

At the beginning of treatment patient complained of headache, vertigo, hot flashes.

B.	60	8/22/45	216	158/90	100
		1/4/46	193	180/94	90
		2/10/46	182	160/80	90
		3/28/46	183	160/80	90

4. The menses were re-started with its psychological value.

5. Several patients were able to become pregnant after many years of sterility.

6. Many overweight patients lost thirty pounds in preparation for pregnancy, after which we held their weight gain to thirty or thirty-five pounds so that they came to the delivery room at their usual weight.

7. Many pregnant, obese patients were able to hold their average weight rather than gain another fifty pounds, which is usually the case.

8. Many patients with callouses, arthritis of feet and knees were improved by loss of weight.

How is weight reduction accomplished? In my opinion there are several rules:

1. Time—If you are not willing to give as much time to this type of patient as you would to a pneumonia or surgical case, then tell the patients you don't do this type of work, and refer them to one who does.

2. Examine the patient—The urine for diabetes and nephritis; heart and lungs, pitting edema, etc.; also, for signs of obvious marked gland disturbances, which should be referred to an internist; check for ulcer history as the diet may be too rough.

3. Explain the diet—Most people do not know much about diet. Such phrases as "cut down on what you are eating" or "cut down on sweets" mean nothing. People judge diet by their own food. Most fat people insist they do not eat much. One of my patients said, "All I ate for supper was a pint of sweet milk, a can of pork and beans, a can of soup, four slices of bread, a pint of ice cream and two slices of cake." Another patient came in worrying about her small son not eating. "Why," she said, "all he had for breakfast was two eggs, two glasses milk, three pieces toast, butter, honey and

two strips of bacon; he didn't touch his grits!" I use the Government Basic Seven: eggs, meat, citrus fruit, milk, butter, vegetable, wheat—explaining that these foods are necessary for vitamins, minerals and proteins, etc., and are necessary for health. Carbohydrates are for energy, and our requirements vary with physical exercise. When a patient says, as they often do, "I had a B.M.R. and have gland trouble," I say, "OK, if your glands are low and you burn up food slower, then you will have to leave off energy foods; it's too bad we all can't eat cake, pie, candy, etc., and keep our weight. If your body can't handle these, you'll have to stick to the Basic Seven. What I want you to do now is stick to the Basic Seven which is less food than you need so you will draw on your fat for food until your weight reaches the point you desire, then add energy foods and watch the scales. If you stay the same, you are using all you eat; if you gain, you are eating more than you need. A good basic diet over a long period of time is the safest way to lose."

4. Write down the diet—Patients will not follow complicated diets nor read and study out complicated-looking diet slips. I write on a prescription blank:

Breakfast

1 egg, ½ slice toast, butter, orange juice, black coffee.

Dinner and Supper

Lean meat, three vegetables (yellow, as carrots and corn, or green, as string beans) ½ slice bread and butter, buttermilk or tea with saccharine.

Many people say they eat only two meals a day. I tell them it is too long to go from supper to dinner; their blood sugar gets low; they do not feel as well and also eat more at the next meal. I ask them to fix their plate three times a day as given on the diet, eat it and stop, and do not eat between meals. Most people do not count the Coca-Cola, sandwich, candy, etc., they eat between meals. When the diet is explained and the above diet list given, I find most overweight people admit they overeat.

5. Explain the medicine—it is a mild stimulant that overcomes that weak, hungry feeling people have who eat less than usual. I find most people are not hungry at breakfast; so I ask what hour they eat breakfast and dinner and give the medicine two hours after each meal, never after 3 p.m. I tell them to report any nervousness or palpitation of the heart.

The drug used in most of these cases is benzadrine sulphate. It comes in 5 and 10 mgms tablets. I find it less expensive to prescribe 60, 10 mgms. tablets, and advise taking ½ tablet as the dose. There is also dexadrine sulphate, 5 mgms., which is said to have twice as much cerebral stimulation with less side effects. One or two of my patients who were nervous with benzadrine sulphate could take dexadrine sulphate. I use dexadrine sulphate altogether

now, $\frac{1}{2}$ tablet twice a day. I also give thyroid grains, one daily, to most cases. I always write "Non rep." on the prescription in order to keep it under control, as there may be some danger of habit formation, although I have not had this trouble.

6. Be positive—"You can lose weight!" "This medicine will kill your appetite!"

7. "Don't weigh till you return to office in four weeks—" Weight varies from day to day, also with time of day and proximity of meals. I weigh 155 on entering office in the morning and 152 on leaving. Penny scales vary. I have had patients come in discouraged because they had lost only six pounds, to find the loss actually ten on the scales in my office. I do not go in for exercise "to help the figure," as most cases "shape up" with weight loss. I wonder if the pep talks of explaining the diet and the moral support given by monthly visits to the office are not the main reasons for these people losing weight, rather than any drug. Already, several patients, after a year, have gained ten to fifteen pounds and have

come in again saying they could not lose weight by themselves but could while being under supervision. I recommend losing only forty pounds, followed by a six-months' rest. This is to avoid prolonged use of dexadrine and to prevent neighbors telling the patients how bad they look. The neighbors are so accustomed to the fat-looking faces that they say the patients look bad when their weight is normal.

SUMMARY:

1. Most fat people overeat.
2. The benefits of losing weight are: Patients feel better physically and psychologically, re-start menses, become pregnant, lower blood pressure, lower pulse, less foot and knee trouble and backache.
3. And it can be done with dexadrine sulphate, $\frac{1}{2}$ tablet 2 hours after breakfast and lunch, if you take time to examine the patient, explain the diet, write down the diet, explain the medicine, be positive, and have the patients weigh only at the office.

The Journal of the South Carolina Medical Association

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----- Florence, S. C.

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Office of Publication: (In care of the Editor)

----- Florence, S. C.

Subscription Price

----- \$3.00 per Year

 DECEMBER, 1946

HIROSHIMA AND BETHLEHEM

Hiroshima, city of death,
 Harvest of the gods of war,
 Emblem of man's ability
 To destroy his fellow man,
 We shudder at the mention of thy name.

First victim of the atomic age,
 Art thou an omen of the days to come?
 Was the blast which killed thy people
 The opening chord of the March of Death
 Which shall some day lay waste
 The cities of the Earth,
 As thou wast laid low,
 O, Hiroshima?

Bethlehem, birthplace of the Prince of Peace,
 Our hearts grow warm
 At the mention of thy name.

Sing again for us
 The song which was sung upon thy hills
 Two thousand years ago,
 "Glory to God in the highest,
 Peace on earth and good will among men."

As the Great Physician walked through thy streets
 And healed the bodies
 And changed the lives
 Of thy children, long years ago,
 O, Bethlehem,
 So must He walk upon the earth today,
 Touching the hearts of his people,
 Teaching them to love their God
 And to love their fellow-man.

How else can we find peace,
 A lasting peace,
 Than through thy greatest Son,
 O, Bethlehem?

NEW BLOOD

As we have visited meetings of county and district medical societies, we have been impressed with the number of new faces and younger faces among those in attendance. The time has at last come when our colleagues in the service are becoming re-established in their practices and when men who have never been in practice are opening up their offices for work.

As any physician knows, there are few procedures in medicine which are more valuable than the introduction of new blood into a patient. We hope that our Association will not be classed as a severely ill patient with need for desperate remedies, but we readily acknowledge that the organization can use new energy and new ideas in its planning and program for the future. And we welcome the new blood which has been brought into our organization during recent months.

With the time for the annual election of officers in county and district societies approaching, we might do well to ponder the availability of these newer and returned colleagues for service.

HOSPITALS

With the signing of the Hospital Survey and Construction Act, the nation has embarked on the most comprehensive hospital and public health construction program ever undertaken. Congress has authorized the appropriation during the next five years of \$375,000,000 in Federal funds for the building of hospitals and health centers. Since the Act provided that the Federal share is to constitute one-third of the cost and non-Federal funds the other two-thirds, the total expenditure for this Nation-wide hospital program would approximate \$1,125,000,000.

The share of the Federal funds which will be available to South Carolina under this Act amounts to \$1,976,775 per year for the next five years and \$41,123 for survey and planning.

Needless to say certain definite arrangements must be completed before this money will start coming into South Carolina. First, there must be a survey of the state as to its needs for hospitals and related facilities and programs must be developed for the construction of the additional hospitals, public health centers, and related facilities. Such a survey is now being made under the auspices of the State Planning Research and Development Board. When the survey has been completed the findings will be reviewed carefully by the Board and its advisory council and then

a specific program will be recommended as a chart for the future development of the state.

Secondly, a state agency (either some agency now in existence or a new agency) must be designated as the agency to set forth a hospital construction program and to provide for and assist in the construction of the individual projects. Furthermore, the agency must establish minimum standards for the maintenance and operation of hospitals which receive Federal aid under this plan. So far no such agency has been established and it will be incumbent upon the coming General Assembly to designate some agency now in existence or to establish some new agency to carry on this work.

Under the Hospital Survey and Construction Act, Federal funds will be available up to thirty-three and one-third percent of the construction costs. The other two-thirds of the cost must come from a local community, the county, or the state. The plan also provides for the participation of non-profit institutions which may not be supported by taxpayers' money. In such an instance sixty-six and two-thirds percent of the cost would have to be met by the local institution.

ANNUAL MEETING

Good progress is being made toward completing the plans for the annual meeting which will be held at Myrtle Beach, May 6-7-8.

Three outstanding physicians have been invited by Dr. James McLeod, President, to address the Association and all three have accepted. These physicians are Dr. Earl Moore of Johns Hopkins, Dr. Eugene Pendergrass of Philadelphia and Dr. A. W. Adson of the Mayo Clinic.

The balance of the scientific program is being arranged by the scientific committee of which Dr. L. E. Madden of Columbia is chairman. Any member of the Association who desires to present a paper should communicate with Dr. Madden immediately.

POST-WAR QUESTIONNAIRE

A post-war questionnaire, prepared by the National Emergency Medical Service Committee of the American Medical Association, has been sent to all physicians who have been discharged from the army and navy medical departments. We urge that all ex-service men cooperate with this committee by filling out and returning these questionnaires immediately if they have not already done so.

The Ten Point Program

M. L. MEADORS, DIRECTOR OF PUBLIC RELATIONS AND COUNSEL

CHRISTMAS, 1946

At this season of the year even the most inept can scarcely resist the impulse to express thoughts appropriate to the spirit of Christmas. And after almost 2000 years, it is virtually impossible to give new expression to any of the thoughts which naturally arise when we contemplate the Christmas Season. Truly, everything that might be said, has been said.

But it is one of the wonders of the occasion that the thoughts concerning it lose nothing of their appeal and fascination; that their expression bears repetition, year in and year out. Though we never learn, the old lesson never fails to attract and interest us, for a few days at least, each year.

So this is the time of all the year when we are privileged to be idealistic in our thoughts and in our expressions, when it is difficult for even the "Scrooges" to retain their cynicism or what we are wont to call the "realistic attitude" toward life. Perhaps the reason why the spell of Christmas takes hold annually of so many, is because somewhere deep within the individual with the most hardened exterior, the most cynical outlook, there remains the need, the subconscious craving to share the feeling toward his fellow man which is the very heart of Christmas. Perhaps that is the basis of the hope of the human race. While the spark remains, the fire of human understanding may yet kindle.

And there has never been a year when the observation of Christmas has been more appropriate than 1946. As the world hesitates, a few steps removed from the black pit containing the smoking ruins which are the result of the latest expression of mankind's supreme folly, and gropingly attempts to find its way through the maze of human selfishness, greed and ambition, toward a course which may postpone another war, its leaders could do nothing better than suspend all other activity, and focus their energies and attention upon contemplation of what Christmas stands for. When a sufficient number, in this and other nations, become truly *men of Good Will*—toward our fellow men—then and then only will we merit or may we expect *Peace on Earth*.

DOCTORS AND POLITICS

(The following article is not, as might have been supposed, a product of the year 1946. The title arrested our attention as we leafed casually through some of the old files of this publication. It is

interesting to note that the idea of active participation of doctors in politics is not new—even in South Carolina. This is an editorial reprinted in full from the Journal of the South Carolina Medical Association of April, 1908!)

The following letter, written by Dr. C. S. Bacon, of Chicago, to the Journal A.M.A. should be carefully read by every healthy-minded physician in the United States:

"Last year you published the very valuable article from Dr. Charles A. L. Reed, chairman of the Committee on Medical Legislation, on "Medical Legislators of Two Republics." In this article and in other contributions, Dr. Reed has called attention to the lessons of his own experience in matters of legislation. He has learned, as have others, that if physicians want something done in the legislatures, or anywhere else, "they must do it themselves, not send agents who know nothing about what is wanted. When physicians get together and agree on what they want and then move forward in numbers, they generally succeed. A new era has arrived in the history of the profession, one in which strong representative physicians, busy men in large practice, find it consistent with their dignity and profession to take part in practical politics for the good of the profession and the community.

It is evident that Dr. Reed has been practicing what he preaches in the recent campaign for election of the members of the Ohio State Republican Convention, states, among other things:

The physicians of the state were organized by Dr. Charles A. L. Reed of Cincinnati, for the purpose of getting representation in the convention. They have succeeded beyond their expectations and there are the names of 105 physicians on the roster of the great body now in session here.

The published details of the convention show some additional facts of interest. The physicians number one-eighth of the whole convention. They are all representative men. They met in caucus and determined what they wanted in the organization and in the platform. The presidency went to Secretary Garfield, but Dr. Reed was made the first vice-president of the convention. The committees on rules and on permanent organization, and, most important of all, on resolutions, each contained a strong representation of physicians. The result according to published reports, was the full realization of the object that the physicians had in view, namely, the adoption by the convention of a plank in its plat-

form committing the party to "the organization of all existing national public health agencies into a single national health department."

The movement for a national department of health was begun by the American Medical Association very early in its history and has been agitated since then with more or less zeal by the Association and the profession. This is the first time, however, that a plank favoring the proposed national department of health was ever adopted by a political convention. It is no small cause for congratulation that Dr. Reed and his Ohio colleagues have succeeded in making this beginning.

They, no doubt, appreciate better than any one else that this is only a beginning. The declaration of a platform, to amount to anything, must be ratified at the polls and redeemed in the legislatures and in Congress. To do this means participation in the campaign. It means, furthermore, that physicians must go to the legislature, not as supplicating committees craving a favor, but as members with power to vote. It means that physicians must go in increasing numbers to Congress—to the House and to the Senate. The movement for a national department of health probably never will succeed until the medical profession sends at least some of its strong men like Reed, Welsh and Mayo to champion the cause of public health in the halls of Congress.

The political activity that has been displayed by the physicians of Ohio ought to be taken up in every other state. Declarations in behalf of a movement to unite under one head all of the national agencies of public health ought to be made by every party in every convention in every state, and in every national convention held this year. There are urgent reasons why this should be done. The cause of the proposed department of health is one and a sufficient one. But in addition to this, it is known that within the next eighteen months a prearranged effort will be made to destroy the force of existing medical laws in several states, but particularly in Ohio, New York, Massachusetts and Illinois. The conspiracy has already been hatched. It behooves the medical profession of all the states to be on guard all the time, but in the four states mentioned it is imperative that the guard be placed directly within the halls of legislation. The physicians of the different states ought to furnish 20 per cent of the members of every legislature elected this year. If this is done state medical laws will be safe and, with additional representation of the medical profession in the Senate and House of Representatives at Washington, the legislation in public health so necessary will speedily become an assured fact.

The doctors have a duty to perform and we believe they are going to perform it. In the State of South Carolina there should be in the Legislature an average of one doctor from each county. It would be an easy matter, probably, for each county medical so-

ciety to prevail upon one of its members to run for legislative office, and the consistent and energetic support of the county society membership would, in every case, insure his election. Why not adopt this plan? No greater piece of patriotism could be practiced.

A HEALTH SERVICE SYSTEM FOR THE FUTURE

KINGSLEY ROBERTS, M.D.*

*(Reprinted from New York Medicine, November 5, 1946)

(The inclusion of the following article does not mean that all of the views expressed are shared by this Department. In some respects, however, it represents an unusual approach to the problem, and, being the expression of a physician, should be interesting to other members of the profession.)

No one disputes that there are grave inequalities in the distribution of medical care. The medical profession and the public alike recognize this situation as a fundamental problem. Both profession and public have set out to find the best working answer to the question: "How shall we secure for all the people the maximum medical service for their dollars?" Public opinion has already forced the drafting of far-reaching legislation. If physicians do not help solve this problem, the lay public will find a solution of one kind or another without them.

Largely because doctors have taken so little part in it, the debate has so far been centered upon financing of medical care. As a physician, I think that at least equal concern should be given to the question of what kind of care the medical dollar buys, quite apart from how it is raised. This is the decisive half of the problem—the one to which the medical profession is especially qualified to contribute.

I should like, therefore, to emphasize the quality of medical care in this discussion, rephrasing the question at issue to read: "How can medical service of high quality and low cost be brought to the greatest number of people?" The phrase "low cost" does not mean "cheap." There is no such thing as good cheap medical care. When I speak of medical care of high quality, I am echoing the thoughts of the late Hugh Cabot when he said that probably it was better for a person to get no medical care than to get medical care of poor quality.

My own experience in medical practice since 1920 leads me to the lamentable conclusion that a great deal of medical service paid for under any of our existing systems—prepayment or fee-for-service—is unnecessarily bad. Neither the doctors, the educators, legislators, nor the public is entirely to blame. Doctors, specifically, are at fault, however, because they

slip too easily into the attitude that their profession is above reproach and beyond criticism. Doctors, therefore, have been the last to recognize the inadequacies of the existing system of medical care: "solo practice."

Solo medical practice fails to realize the potentialities of modern medical science in several important respects. First, no man can command the full range of knowledge and skills that medical research has made available. Second, because most practicing physicians cannot afford post-graduate education, the practice of medicine lags far behind the science of medicine. Third, the income of the single physician cannot finance the equipment, laboratory facilities and specialized personnel needed to use modern resources without charging patients unduly.

Furthermore, the existing system fails to realize that medicine is a social and economic as well as a physical science. The family is the unit of medical care. Yet, how many physicians, when one member of a family is ill, give thought and attention to the attitudes and problems of the other members? The health of a family obviously depends upon the living and working conditions of its members, but there is now no place in medical education where consideration is given to these important factors. Individual physicians can hardly be blamed for this situation, in view of the neglect of medical economies in the medical schools. Finally, there is no adequate place in solo practice for preventive medicine, for organized promotion of public and personal health programs that have proved so effective in reducing the incidence and severity of illness.

Medical care is worst in rural areas. High medical school and urban standards will be valueless as long as they are out of reach of the majority of the population. Something must be done to make good medical care universally available. To my mind, the solution for the problem of distribution rests upon three basically inseparable essentials which hold good for any financial basis.

1. Prepayment for comprehensive medical care.
2. Medical group practice units as the medium for distribution of the services.
3. Preventive medicine on a par with therapeutic medicine.

Since my concern is with what the medical dollar will buy, I will not discuss the many kinds of payment methods by which people of different income levels buy their medical care. In spite of all the plans, some good some bad, we eventually reach the point at which the lowest income groups cannot be medically self supporting, under any system of financing. These people must be cared for. I believe that this problem should be solved locally. The principle of employer contribution is now accepted. I believe that we must eventually use tax funds as well.

Group practice is the concern of this paper because it bears directly and decisively upon the question of what the medical dollar will buy. If prepayment is to buy comprehensive care, including preventive medicine, then the care must come from organized medical groups.

Physicians and their patients both know that no one man can any longer be a complete physician. Modern medical care involves the use of extensive laboratory procedures and technical personnel to conduct them. It calls for nurses and a variety of specially trained therapeutic technicians. All these raise the cost of medical care, and in most cases keep it beyond the means of the average patient. Clearly, then, to care properly for the average patient, the cost of these items must be made less. This can best be done by group practice, where resources and personnel are pooled, with consequent reduction in operating costs and lower costs to the patient.

What is a medical group? It is an association of physicians of different skills, who use common equipment and nursing, technical and administrative staff, have a formal pattern of professional collabora-

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tion, a definite relationship as a group with a hospital or hospitals, and a unified financial administrative organization.

The two key specifications in this definition are "a formal pattern of professional collaboration" and "a unified financial and administrative organization." The pattern of professional collaboration simply means that the consultation and cooperation among the group's specialists be definitely planned to be readily available for the patient's benefit. Two of the inestimable advantages are the unit system of medical records, to which each physician contributes and regular staff conferences, in which all the physicians collaborate. A unified administrative and financial organization requires that income from patients be pooled and financial relations with patients handled in the name of the group.

The institution of group practice is no better than the men who compose it. Some groups, like some physicians, will chisel, perform abortions and split fees. Nonetheless, group practice can and does exert an influence of its own, because it brings into clinical practice something of the spirit that prevails in the medical school and teaching hospital. The doctor who works in collaboration with his colleagues must meet standards and, in turn, set standards of performance such as he forgets early in a solo career. Cross-checking of his judgments in consultation with his specialist-partners becomes the rule rather than the exception of everyday practice. I believe, in general, and other things being equal, a doctor will be a better doctor in a group practice unit than he would be in solo practice. It is interesting to note in passing that more and more veterans of war medicine are interested in going into group practice.

Groups now in existence range from a group of four physicians to the high of six hundred on the Mayo Clinic staff. Groups can be set up under the auspices of hospitals, industrial concerns, or consumer organizations, or on a private basis under the physicians' own control. They may also be sponsored by government—federal, state or municipal. Financing may come from endowments, fees-for-service, taxes, voluntary health insurance or indemnity and industrial insurance.

The most significant classification of present groups is by scope of service. The narrowest are the diagnostic clinics, like those at Johns Hopkins and Mt. Sinai Hospitals which are limited diagnosis and report to referring physicians. Some reference groups provide diagnosis and treatment to patients with more or less unusual or complicated conditions.

Most significant to the whole pattern of medical practice is the "service group" that furnishes general family care, backed up by the more usual specialist services such as surgery, otolaryngology, obstetrics and pediatrics. Serving patients within its own community, it is general practitioner of group medicine.

The already large number of service groups is growing steadily. There are now between 400 and 600 chiefly in the West, Midwest and South.

Such a group may be organized and controlled by the physicians themselves, usually, though not always, on a partnership basis. It may—like the Gundersen Clinic in Wisconsin—derive its income from fees-for-service. Or, like Mary Imogene Bassett Memorial Hospital at Cooperstown, New York, it may be sponsored by outside aid and only partly supported by fees-for-service. Endicott-Johnson has provided such service for its employees for nearly thirty years.

The most interesting aspect of the service group for the future of medical care is its adaptability to prepayment financing because it renders comprehensive medical care. Thus, the Los Angeles Ross-Loos Clinic, a private group organized and controlled by physicians, has for some years derived a significant part of its income from a prepayment plan. Others have been sponsored by industrial organizations, like the Permanete Health Plan, financed throughout the war by voluntary payroll deductions at the Kaiser shipyards. Other examples of prepay-plans successfully sponsored by consumer groups is that at the Standard Oil Company of Baton Rouge, La., sponsored by the employees, who also participate in its management and the consumer-cooperative sponsored Group Health Association in Washington, D. C.

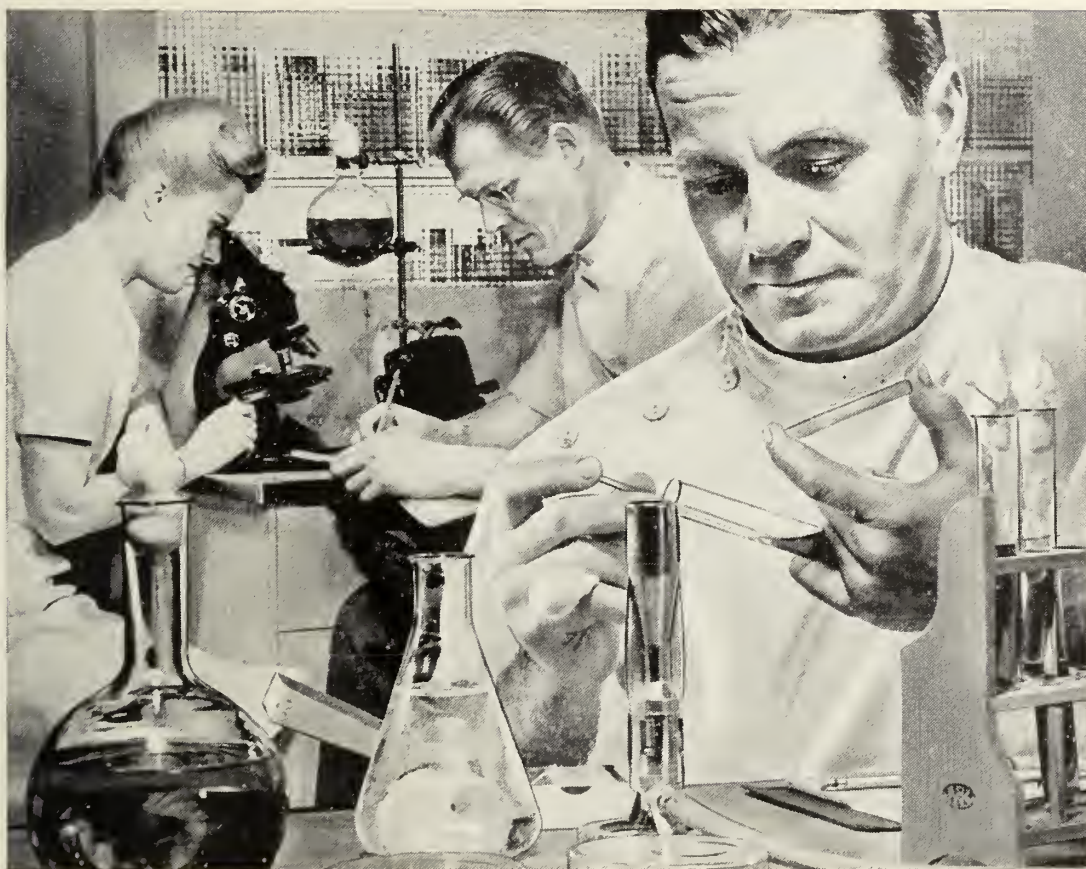
THE RECORD OF CONGRESS IN SOCIAL SECURITY (1946)

"The Second Session of the Seventy-ninth Congress devoted considerable attention to social security, including a freeze of the pay-roll tax and broadening of the program.

Faced with automatic increase of the Old Age and Survivors Insurance tax January 1, Congress gave final approval to an amendment (H.R. 7037) providing for (1) the freezing of the one per cent tax rate on employers and employees for old age and survivors insurance for another year; (2) coverage of 200,000 maritime workers under unemployment compensation; (4) increasing benefits under old-age assistance, aid to dependent children and to blind persons.

A compromise to increase by \$5.00 federal contributions to states for old age pensions broke a stalemate in Senate-House conference on the social security bill.

Security Agency: Reorganization of the Federal Security Agency became effective when the Senate failed to confirm House rejection of President Truman's plan No. 2, in the governmental reform program. Shifted to FSA are functions of the old Social Security Board and various health and welfare agencies.



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Crosser Bill: This legislation (H.R. 1362) to liberalize the railway retirement and unemployment compensation program holds significance for other industries by making a pattern for possible broader revision of social security. Under the rail unemployment insurance program (1) maximum daily benefits are increased from \$4 to \$5, (2) maximum duration raised from 20 to 26 weeks, (3) maximum amount payable boosted from \$400 to \$650, and (4) payments for unemployment caused by non-occupational sickness or injury is provided.

Cash sickness benefits will be paid by railroads out of taxes previously collected for unemployment compensation. Disability benefits are increased. Taxes are increased to a maximum of 15.5 per cent (9.25 per cent from employer and 6.25 per cent from employee).

Hospital Aid: A Federal-State grant-in-aid program to survey the need for hospitals and provide for their construction is authorized in the Hospital Survey and Construction Act (S. 191). The Federal Government contributes \$75 million a year, for five years, under a variable grant formula (States receive varying proportions of the cost based on per capita income).

Senate Study of Social Security: A full and complete study and investigation of all aspects of social security is authorized in Senate Resolution 320. A six-member advisory council will be appointed to report its findings to the Senate Committee on Finance.

Health Insurance: Extensive hearings were held but no Senate-House action taken on the Wagner-Murray-Dingell Bill (S.1606) for a national compulsory health insurance plan.

USES: Return of the United States Employment Services to the states next November is provided in H. R. 6739. This shift was urged by the Chamber."

(The foregoing is reprinted from *American Economic Security*, publication of the Chamber of Commerce of the United States of America, August 1946.)

STATE CONTROL OF DISABILITY BENEFITS

In the welter of talk and publication regarding the proposed national legislation for compulsory health insurance, we are inclined to overlook at times the current developments in state statutes, enacted or proposed, directed toward the same end. Some of these provide for monopolistic state disability benefit arrangements, and are subject to the same objections that apply to monopolies generally—as well as to objections on other counts. It is not too early for us in South Carolina to begin giving thought to this subject from time to time. We can benefit by the experience of some of our sister states, and there may come a time when knowledge of proposed and

existing arrangements there may stand us in good stead. The following article, by an insurance company official, is reprinted from the *National Underwriter* of October 17, 1946.

"Reasons why a compulsory disability benefit system, if enacted, should not be of the monopolistic type but should allow private insurance and self-insurance, were cogently set forth by W. A. Milliman, second vice president and associate actuary of Equitable Society in his talk at the annual meeting of the Illinois Chamber of Commerce at Chicago.

Contrasting the California act with the Monopolistic Rhode Island plan, he said that in California it is expected that voluntary programs, by maintaining the normal employer-employee relationship, will eliminate many improper claims and that it is probably also true that voluntary plans will generally be adopted by the more progressive employers, who wish to provide liberal, well-designed benefit programs for their employees which include disability benefits as only one part of a broader program.

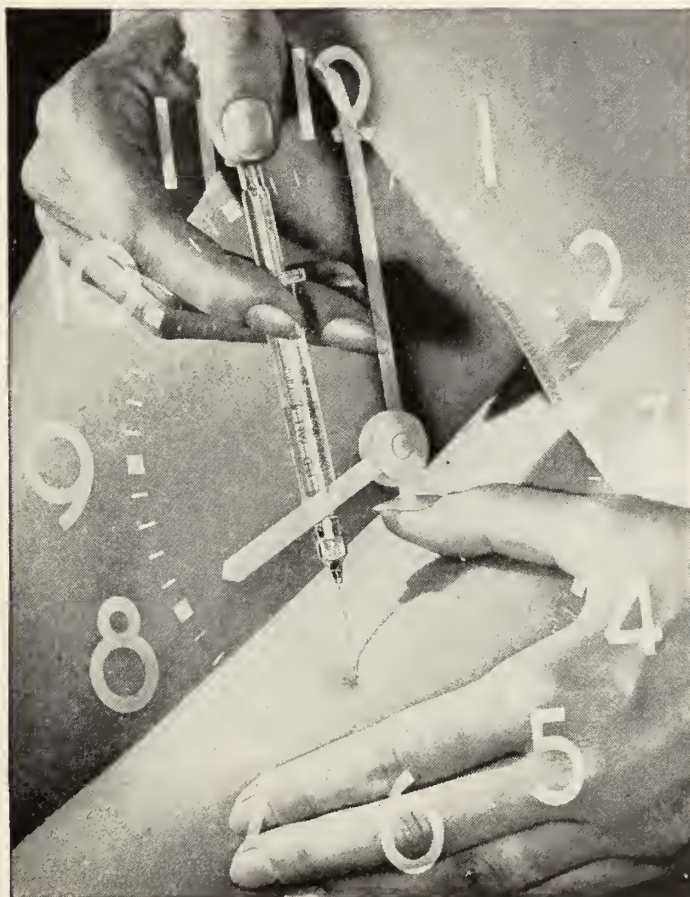
Mr. Milliman cited the statement of the policy adopted two years ago by the U. S. Chamber of Commerce as a sound approach to the problem. It is said that employers who have not done so should explore the possibility of providing for their employees some protection against non-occupational disabilities and sickness, and that if after a reasonable period such efforts still leave substantial gaps in coverage, only then should public action be taken. If the latter is done, it should be at the state and local levels rather than federal, and if passed should permit voluntary plans to operate as alternatives to government plans.

As to whether we now have substantial coverage Mr. Milliman said we do not know just how much coverage is provided through wage continuance plans, employee benefit associations, labor union plans and other self-administered plans. However, nation-wide statistics which are available as to the number of workers who are covered by group insurance policies providing disability protection and information compiled by the New Jersey State Chamber of Commerce with respect to protection for New Jersey employees provided by other means, indicate that about 40% of employees covered for unemployment compensation benefits also have disability protection provided through their place of employment.

The volume of such protection has increased rapidly over the past several years, the number of employees covered for group disability insurance having more than doubled in the past seven years. Further substantial growth is in prospect, and it is the belief of many, he said, that this growth of voluntary plans will make governmental action both inadvisable and unnecessary.

One of the primary defects of a monopolistic governmental plan of disability benefits of the Rhode

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carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

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Island type arises from the fact that it treats disability as a special type of unemployment and ignores the continuing employment relationship which exists in substantially all cases. The fact is that most workers who become disabled have jobs and, upon recovery, return to those jobs. Unemployment in these cases just does not exist. By ignoring the continuing employment relationship these plans would omit the employer from responsibility for supervision and administration of the benefits. The employer, however, is the one party who, by the very nature of things, is best equipped to guard the plan against abuse.

Under the Rhode Island plan the reverse of the usual pattern of incidence of illness prevails, the claim rate being highest during the summer months and lowest during the winter. In 1945 the payments during May, the month of highest payments during the year, were 169% of the payments in January. The payments in May, June and July accounted for payments 57% greater than the payments in the months of January, February and March, the months during which real sickness rates are highest. This correlation between the high point in sick benefit payments and the best vacation weather can scarcely be pure coincidence, he observed.

While the financial loss resulting from this type of experience must not be ignored, the loss cannot be measured in terms of dollars alone. It is measured in terms of decreased efficiency, decreased production and in lowered standards of living. Perhaps the most important and the most insidious effect is that it encourages a substantial segment of the population to indulge in petty fraud. The only way to control such petty frauds and abuses is to place responsibility for the administration of claims with some one who can and will protect the plan of disability benefits from illegitimate claims. The employer is ideally situated to exercise this responsibility.

Not only does a monopolistic state plan tend to produce financial and social losses, it also tends to deprive employes of more liberal plans of benefits which employers may have in effect, Mr. Milliman said. Many employers have disability benefit plans in effect which are more liberal in at least some respect than the typical compulsory plans which have been proposed. These greater benefits may be in the form of higher weekly rates of benefit (even to the extent of continuation of full salary), or provision for commencement of benefits after a shorter waiting period of disability, or provision for continuing benefits in effect for a longer period during disability.

PRIVATE HEALTH INSURANCE

(The Eastern Underwriter, Sept. 20, 1946)

Voluntary insurance protection against illness and accident through Group insurance in private companies is carried by many millions of Americans, which seems to indicate little demand for state operated schemes being agitated. A survey by Life Insurance Association of America shows that 5,921,360 persons were carrying Group accident and health insurance at the end of last year involving premiums paid of \$115,989,000. Group Hospital expense insurance was held by 4,371,350 employees and on 3,432,320 members of their families and Group surgical expense coverage was provided 3,948,565 employees and 1,587,669 members of their families. In addition several hundred thousand employees and dependents had Group medical expense insurance providing general coverage against doctors' charges.

Premiums for these three classes of health insurance amounted during the year to \$90,195,000. Hospital, surgical and medical care insurance under such plans as the Blue Cross and individual policies were not included in the survey. Neither did the survey include Canadian business of the companies.

PUBLIC HEALTH NEWS

RAPID TREATMENT CENTER

The Rapid Treatment Center, which opened near Florence, November 1, is still operating with a very limited capacity owing to a lack of personnel. Dr. C. L. Guyton, Director of the Division of Venereal Disease Control, has announced that all County Health Departments will be notified when it will be possible to increase their patient quotas.

10,145 X-RAYS MADE IN SUMTER COUNTY

The Sumter City-County Health Department and the Sumter County Tuberculosis Association have

announced that a total of 10,145 chest X-rays were taken during the five weeks mass survey held in the County from October 1 to November 8.

Among the thousands X-rayed with the State Board of Health's portable X-ray unit were industrial workers, all white students in the County over 15 years of age, all negro students over 12, teachers, housewives, business men, and others.

Readings were done by Dr. M. C. Parrish, roentgenologist of Tuomey Hospital, and the work had the hearty endorsement of the Sumter County Medical Society.

Cooperating in giving publicity to the survey were the service organizations, radio and newspapers, Summer Merchants Association, local theaters, and industrial insurance agents.

PRINCIPAL PROVISIONS OF FEDERAL HOSPITAL AID LAW

The purpose of this law is to assist states to inventory their existing hospitals and related facilities, to survey the need for additional facilities, to develop programs for the construction of public or other non-profit hospitals, health centers and similar facilities, and to assist in the construction of such institutions in accordance with these programs, as approved by the Surgeon General.

An appropriation of \$3,000,000 is authorized for the state surveys and plans. To date \$2,350,000 has been appropriated by Congress for assistance to states in surveying and planning and for administrative expenses of the U. S. Public Health Service in connection with the program.

A state plan must be developed on the basis of the survey showing the need for additional facilities in accordance with regulations to be issued by the Surgeon General. The priority of need must be listed.

The plan shall provide that there be no discrimination as to race, creed, or color, but separate instructions may be provided for certain population groups.

The state plan must be approved by the Surgeon General before any construction funds can be made available to the state.

After a state agency and an advisory council have been designated by the state to conduct the survey and to make plans, the state may apply for financial assistance in making the survey and plans. Within allotment ceilings, the federal share will be one-third of these costs.

The act authorizes an appropriation of \$75,000,000 each year for five years to the states for construction purposes.

Allotments to individual states will vary in amount. Population will be one factor, and in addition, the average per capita income will be used in the allotment formula in such a way that states with a lower per capita income, where there is relatively greater need for medical facilities, will receive proportionately larger allotments per capita. South Carolina, for example, will receive \$2,017,898, while New York will receive only \$3,217,492.

Minimum standards for operation must be fixed by the state before July 1, 1948.

Before any application for a construction project can be considered three requisites must be met:

1. The state plan must have been approved.
2. The project must be in conformity with the state plan and relatively high in its list of priority needs.
3. Certain assurances must be made including: (1) Two-thirds of the cost of construction must be available in non federal funds. (2) Assurance that the institution can be maintained and operated without additional assistance after it is constructed.

The construction funds are to be distributed among base, intermediate and rural areas in accordance with priority of needs.

Priority in construction will be given to areas having the greatest need for additional facilities.

Federal participation ends after each facility is built. It then becomes a state and local responsibility.

REPRINTS ON "OUR BABY" OFF THE PRESS AVAILABLE NOW FOR FREE DISTRIBUTION

Reprints of "Our Baby," the popular booklet co-authored by Miss Laura Blackburn and Miss Julia Brunson, are off the press and copies for distribution may be obtained by writing the Division of Maternal and Child Health, State Board of Health, Columbia, S. C.

Attractively bound and adequately illustrated with interesting photographs by E. S. Powell, "Our Baby" has been highly prized by every family fortunate enough to get a copy. Sound, clear advice about feeding, bathing, nursing, weaning and many other things one should know about the care of a baby make it an invaluable source of information for every mother.

Written under the direction of Dr. Hilla Sheriff, Director of the Division of Maternal and Child Health, and approved by the Division's pediatric consultant, "Our Baby" is something of which the State Board of Health will always be proud.

STREPTOMYCIN DISTRIBUTION

The Civilian Production Administration has announced that during the month of November all hospitals may order streptomycin from suppliers of their choice without restriction. The current supply-demand situation makes it advisable partially to relax control of distribution for this month. It is pointed out, however, that it may be necessary to impose restrictions again as to quantities, consignees and sources of supply, and that no physician or hospital should assume that the quantity obtainable in November will be available in subsequent months.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. S. Harry Ross, Anderson, S. C.

Publicity Secretary: Mrs. J. R. Young, Anderson, S. C.

The Executive Board of the Woman's Auxiliary to the South Carolina Medical Association met on October 9, 1946 at the home of Mrs. S. Harry Ross, 719 Boulevard, Anderson for its regular Fall meeting. Mrs. Ross presided at the meeting. Mrs. H. L. Timmons of Columbia opened the meeting with prayer. Mrs. Ross welcomed the members and guests. The business sessions followed. The minutes of the Post-Convention Executive Board Meeting were read and recorded by the Secretary, Mrs. P. M. Temples of Spartanburg. The President's report and plans for the year were given.

A nominating committee was elected as follows: Mrs. Vance W. Brabham, Orangeburg, Chairman; Mrs. W. H. Folk, Spartanburg and Mrs. T. A. Pitts, Columbia.

Mrs. Ross then introduced the guest speaker, Dr. James McLeod, President of the South Carolina Medical Association. Dr. McLeod spoke against government control of medical care, which would regiment the public and not the doctors, being just the reverse of what the public thinks it is. He spoke at length on the part the Woman's Auxiliary can play in this program and concluded with the statement that South Carolina is at the bottom of the list in health and will continue to be until an increased health program is inaugurated that will remedy the situation.

Dr. Ned Camp, Anderson, a member of the Advisory Council, was introduced by Mrs. Ross. Dr. Camp made several suggestions for the work of the Auxiliary and urged the cooperation of the members in organizing new Auxiliaries. "There are many new doctors, and many new doctors' wives," he said, "and it is up to you to bring these women into the Auxiliary." At the conclusion of the program, Mrs. Ross invited the guests into the dining room for a buffet luncheon.

On the table was a linen cut-work cloth, yellow dahlias and yellow lighted tapers in silver candlesticks. A turkey luncheon was served followed by block cream and angel squares which were decorated in yellow.

Yellow tomato juice was served in the living room before the guests were invited in the dining room.

Mrs. James McLeod of Florence was present for the occasion.

The ladies were given nylon hose, compliments of Gallant-Belk Company, Anderson, S. C., and the men were given cigarette lighters, compliments of Cochran Jewelry Company, Anderson.

MID-YEAR REPORT AND PLANS OF THE PRESIDENT

Your President has given her best thoughts in plans for the Woman's Auxiliary to the South Carolina Medical Association. It is a great privilege following such splendid leaders as the Medical Auxiliary has had. Your President believes that the South Carolina Presidents would stand among the very best in our Country. Congratulations to them!

It was a great pleasure for your President to find out how South Carolina stood as compared with other states. It has been helpful indeed to have written to many states from every corner of the

United States to find this out. There is such a field for organization in South Carolina. We, together, could do much toward having S. C. organized one hundred percent.

Your President offers for your consideration the following plan:

Our aim this year is "SERVICE TO OTHERS." All of us are interested in all people of course, but don't we owe an especial debt to the youth of our country? Let's think about Health Education for our children this year. All of us know how important it is that children should have hot lunches during school hours. Statistics show that the children's behavior and their marks are much better where lunches are served and certainly their health in general is much better. We have a definite obligation to these children. We are impressed with the fact that we need very much a strong Health Committee since the glaring statistics during the war showed us that half of our boys were physically unfit for service. This is a great challenge to us. The responsibility rests very heavily upon the doctors' wives because they are in a position to know better the conditions than any other group of women. 1st, I would say that we should take some specific project regarding Health Education. Of course, Health Education can mean anything, but with a Health Chairman to work out a definite program *much* could be accomplished. We are all interested in health from every standpoint but the youth of our country should come in for a greater part of our time. There are many things the Auxiliary could do in a concerted effort for the youth of our state. 1st, of course, we would have to have a State Health Chairman to work out a plan.

2nd. Our Student Loan Fund Treasurer reported that we have in the Treasury \$3300.00. We would like to think seriously about putting this money to work. We know the constitution says that it must be a doctor's son or daughter but would you like to think about letting it be other than a doctor's son or daughter because in these very prosperous years, it may be hard to find a doctor's son or daughter who needs to use this money—then shall we let it be idle or just what do you think we should do? Science Service tells us that it will be 12 years before we have enough doctors to render medical aid to our people. It has been three years since we have given anyone an opportunity to use this money. If this continues will we not have lost the incentive for giving to this most wonderful cause? This is suggested for your most serious consideration.

3rd. We hope to have an Auxiliary in each of the 46 Counties before too long and I believe if we could get one doctor's wife in each county to feel the responsibility of calling a meeting it could be done. There is a representation here of the entire state. Won't you send the 1st Vice President, Mrs. J. W. Potts, the names of your friends in the different counties whom you think might be interested in helping to organize.

4th. Your President suggests that in the beginning of the year that the Program Committee meet with the President to outline a suggested program

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PATIENTS TO SWALLOW!*

May we suggest, instead,
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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

for each month in the year, to be changed according to the need of the county.

5th. The National Chairman has outlined the following objectives for 1946-47:

1. To hold an annual school of instruction for training of officers and chairmen in their duties.
2. To form study groups in regard to medical legislation.

3. That we encourage participation in the Medical and Surgical Relief Program.

The Advisory Council of the American Medical Association has requested that the Auxiliaries place special emphasis upon the National Health Program. Last year the following objectives were stressed and we must give added publicity to these objectives:

1. Animal Experimentation
2. Juvenile Delinquency
3. An important place to Cancer Control.
4. Hygeia, our only authentic Health Magazine, and the Bulletin.

I believe it was Tennyson who said:

God gave all men all earth to love,
But since our hearts are small,
Ordained that each should have a spot,
Beloved over all.

South Carolina is *our* beloved spot. Let us as doctors' wives be sure that we leave foot prints in the sands of time, worthy of this God-given profession.

MRS. MEAD 1st PRESIDENT OF PEE DEE AUXILIARY

Mrs. W. R. Mead of Florence was elected president of the Women's Auxiliary to the Pee Dee Medical association at its organizational meeting. The meeting which had a large attendance including women from each county in the Pee Dee, was held at the Country club.

Dr. James C. McLeod, president of the South Carolina medical association, presided. Counties represented were Darlington, Horry, Dillon, Marion, Chesterfield, Marlboro and Florence.

Other officers elected were Mrs. Julian P. Price of Florence, vice president and Mrs. J. D. Smyser of Florence, secretary and treasurer.

In addition a vice-president and secretary and treasurer were chosen for each county, as follow: Chesterfield, Mrs. W. R. Wiley, vice president and Mrs. William Perry, secretary and treasurer; Horry, Mrs. Hal Holmes, vice president and Mrs. Henderson Rourk, secretary and treasurer; Marlboro, Mrs. Paul Barnes, vice-president and Mrs. Prentiss Kinney, secretary and treasurer; Marion, Mrs. Elliot Finger, vice-president and Mrs. Sam Cantey, secretary and treasurer; Dillon, Mrs. E. B. Michaux, vice president and Mrs. William Bethea, secretary and treasurer; Darlington, Mrs. J. M. Wilcox, vice-president and Mrs. R. B. Hannahan, secretary and treasurer.

It was decided that another area meeting will be held in January at which time Mrs. H. Harry Ross of Anderson, state president, will be present.

of general surgery.

Dr. C. Eugene Yeargin is now associated with Dr. I. H. Grimball of Greenville, in the practice of pediatrics.

Dr. J. Warren White of Greenville recently attended a meeting of the executive board of the American Academy of Orthopedic Surgeons in Chicago.

Dr. George Laub of Columbia has recently passed the Board of Otolaryngology.

Announcement is made of the opening of the Bob Seibels, Jr., M.D., Memorial Laboratory, 1336 Pickens Street, Columbia. Special facilities for the study of the RH factor and the diagnosis of uterine cancer by stained spreads of vaginal cytology will be available. In charge of the laboratory will be Dr. R. E. Seibels with Miss Jeanie McGowan Holmes as medical technologist.

BIRTH ANNOUNCEMENT

Dr. and Mrs. J. J. Alton of Columbia announce the birth of a daughter, Susan Gail, on October 29th.

NEWS ITEMS

Dr. George H. Bunch, Jr., is now associated with his father, Dr. George H. Bunch, of Columbia, in the practice of general surgery.

Dr. Eleanor Townsend of Charleston, is now on the staff of the Kentucky Baptist Hospital at Louisville. Dr. Townsend served during the war with the medical corps of the United States Navy, with the rank of Lieutenant Commander. Before she entered the navy she was assistant professor of pathology and bacteriology at Emory University.

Dr. R. G. Latimer has opened offices in Cayce where he will engage in the practice of general medicine.

Dr. Furnan T. Wallace, of Spartanburg, announces the association of Dr. E. M. Colvin in the practice

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DEATHS

Samuel Clifford Henslee

Dr. Samuel Clifford Henslee, 76, died at his home in Dillon on October 29. A native of Ohio, Dr. Henslee received his medical education at the Hospital College of Medicine in Louisville, Kentucky (Class of 1898). In 1899 he located in Dillon where he established a large general practice. Dr. Henslee was active in civic, religious and professional work and was for many years the efficient and loyal Secretary of the Pee Dee Medical Association. Upon his retirement as secretary he was made president of that body.

Dr. Henslee is survived by one daughter, Miss Rebecca Field Henslee of Dillon.

Edward C. L. Adams

Dr. Edward C. L. Adams, 70, an Honorary Member of the Association, died at his home in Columbia on November 1. A native of Richland County, Dr. Adams received his medical training at the College of Physicians and Surgeons in Baltimore (Class of 1903). Following post-graduate work in Philadelphia and Dublin, Dr. Adams established himself in general practice in Columbia. He was a veteran of World War I, having served with the medical corps of the 81st Division in France.

Several years ago, he retired from active practice and devoted himself to farming and to writing, publishing several volumes dealing with the negroes of Richland county.

Dr. Adams is survived by his wife, Mrs. Amanda Smith Adams, and two sons.

THIRD DISTRICT MEDICAL SOCIETY

The annual meeting of the Third District Medical Society was held in Greenwood on November 13, with thirty-one members and seventeen guests present. The scientific papers of the evening were presented by Dr. J. F. Rainey of Anderson and Dr. Arthur M. Shipley, Professor of Surgery at the University of Maryland. Dr. Rainey spoke upon the subject of rheumatic fever while Dr. Shipley discussed the acute surgical abdomen, drawing upon his great experience for illustrative cases. Dr. J. P. Price, Secretary of the S. C. Medical Association, also spoke briefly urging that the Society consider the possibility of holding monthly scientific meetings for the benefit of the smaller counties.

At the business session the following officers, all of Newberry, were elected for the coming year: President, Dr. R. E. Livingston; Vice President, Dr. V. W. Rinehart; Secretary, Dr. A. W. Welling.

The site selected for the 1947 annual meeting was Newberry.

The Third District is composed of the counties of Abbeville, McCormick, Newberry, Laurens, and Greenwood.

Douglas Jennings

Dr. Douglas Jennings, 52, died at Roper Hospital, Charleston, on December 1.

A native of Bennettsville, Dr. Jennings attended the College of Charleston and was graduated from the Medical College of the State of South Carolina (Class of 1919).

Dr. Jennings was a fellow of the American College of Surgeons, a past president of the Tri-State Medical Association, a past president of the South Carolina Medical Association and was a trustee of the Medical College of the State of South Carolina at the time of his death.

Surviving are his widow, Mrs. Mary Grace Edens Jennings, and three sons.



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INDEX FOR VOLUME 42

AUTHOR INDEX

In this Index are the names of the authors of original articles which have appeared in the Journal. Subject Index follows.

B

- Boone, John A.*, The medical treatment of gall bladder disease, 272 (Oct.)
Buist, A. J.: See Maguire, D. L.
Burford, Thomas H.: See Parker, Edward F.

C

- Close, Upton*, A commentator's view of the medical dilemma, 302 (Nov.)

D

- Davis, Junius W. Jr.*, Congenital malformations following rubella in the mother, 190 (July)

G

- Goin, Lowell S.*, The public health, the politician, and the doctor, 274 (Oct.)

H

- Hanna, Charles B.*, The use of curare (introcstrin) in reducing convulsive effects of tetanus, 5 (Jan.)
Hendrix, Wm. T., Obesity in general practice, 332 (Dec.)
Hirschman, Louis J., A proctologist's message to the general practitioner, 183 (July)
Hirschman, Louis J., Some common proctologic conditions of childhood, 267 (Oct.)
Hosball, F. A., Disabilities of the foot, 117 (May)

J

- Johnson, George D.*: See Way, Roger A.
Johnson, George D., The use of histamine compound in the treatment of infantile eczema, 29 (Feb.)

K

- Kelly, Wm. H.*, Anti-histamine agents, 209 (Aug.)

L

- Lynch, Kenneth M.*, Chronic disease of the breast, 111 (May)
Lynch, Kenneth M., Remarks and announcements, 305 (Nov.)

M

- Maguire, D. L.*, Primary cysts of the omentum, 2 (Jan.)
Mathias, Marion L., Helpful considerations in diagnosis of surgical cases of jaundice, 115 (May)

P

- Parker, Edward F., and Burford, Thomas H.*, The treatment of hemothorax and its complications in

thoracic injuries, 325 (Dec.)

- Pollitzer, R. M.*, Post hoc sed non propter hoc, 330 (Dec.)

- Price, Julian P.*, The nutritional status of the people of South Carolina, 186 (July)

R

- Rivers, Arthur L.*, Practical suggestions for the care of obstetrical patients, 298 (Nov.)

S

- Smithly, H. G.*, Sympathetic nerve interruption in the treatment of organic obstructive vascular disease, 241 (Sept.)

T

- Thompson, George E.*, Intestinal obstruction, 295 (Nov.)

W

- Wallace, Furman T.*: See Way, Roger A.
Wallace, Furman T., Some technical considerations in thyroidectomy, 248 (Sept.)
Waring, J. I., Hot weather pediatrics, 211 (Aug.)
Way, Roger A., Johnson, George D., and Wallace, Furman T., Pyelocystostomy in an infant, 246 (Sept.)

Z

- Zeigler, Rowland F., Jr.*, Amenorrhea, its causes and treatment, 213 (Aug.)

SUBJECT INDEX

This is an Index to all reading matter in the Journal. It is a Subject Index and one should, therefore, look for the SUBJECT word, with the following exceptions: "Book Notices," "Correspondence," "Deaths," "Editorials," "Letters from Physicians in Service," "Medical College of the State of South Carolina," state "Societies" are indexed under these titles at the end of the letters "B," "C," "D," "L," "M," and "S," respectively. The name of the author, in parenthesis, follows the subject entry when it is an original article.

For Author Index see above.

A

- "A History of the Case" in Franklin D. Roosevelt's own words, 1 (Jan.)
A proctologist's message, to the general practitioner, (Louis J. Hirschman), 183 (July)
Amenorrhea, its causes and treatment, (Rowland F. Zeigler, Jr.), 213 (Aug.)
Anti-histamine agents, (Wm. H. Kelly, 209 (Aug.)

B

Breast, chronic disease of, (Kenneth M. Lynch), 111 (May)

BOOK NOTICES

Allen, Edgar V.; Barker, Nelson W.; and Hines, Edgar A.; Peripheral vascular diseases, 292 (Oct.)

Anderson, W. A. D., Synopsis of pathology, 266 (Sept.)

Barker, Nelson W.: See Allen, Edgar V.

Bockus, H. L., Gastroenterology (in three volumes), 146 (May)

Brodel, Max, Three unpublished drawings of the anatomy of the human ear, 266 (Sept.)

Conwell, H. Earle: See Key, John Albert

Fishbein, Morris, Common ailments of man, 238 (Aug.)

Hines, Edgar A.: See Allen, Edgar V.

Jackson, C. and Jackson, C. L., Diseases of the nose, throat, and ear, 238 (Aug.)

Jackson, C. L.: See Jackson, C.

Key, John Albert and Conwell, H. Earle, The management of fractures, dislocations, and sprains, 266 (Sept.)

Major, R. H., Physical diagnosis, 238 (Aug.)

Manwell, Reginald D.: See Russell, Paul F.

Mason, R. L. and Zintel, H. A., Preoperative and postoperative treatment, 206 (July)

Masserman, J. H., Principles of dynamic psychiatry, 206 (July)

Mustard, Harry S., Government in public health, 144 (May)

Nelson, Waldo E., Textbook of pediatrics, 238 (Aug.)

Russell, Paul F.; West, Luther S.; Manwell, Reginald D., Practical malariology, 324 (Nov.)

Rypins, H., Rypins' medical licensure examinations, 206 (July)

West, Luther S.: See Russell, Paul F.

Zintel, H. A.: See Mason, R. L.

C

Congenital malformations, following rubella in the mother, (Junius W. Davis, Jr.), 190 (July)

Curare, (Introcostrin), the use of in reducing convulsive effects of tetanus, (Charles B. Hanna), 5 (Jan.)

CORRESPONDENCE

Nachman, Mordecai, 94 (April)

Stokes, J. H., 110 (April)

Wilson, Robert, Jr., 144 (May)

Wyman, Ben F., 79 (March)

Wyman Ben F., 237 (Aug.)

DEATHS

Adams, Edward C. L., 1876-1940, 349 (Dec.)

Ariail, Cauthen Clyde, 1890-1946, 178 (June)

Bolin, Grover Cleveland, ?-1946, 146 (May)

Brooker, Lucius Cuthbert, ?-1946, 146 (May)

Donnald, Edgar Rasor, 1877-1946, 146 (May)

Fennell, John L., 1878-1946, 110 (April)

Griffin, Harry Hammond, 1876-1946, 324 (Nov.)

Harris, Caleb Wooster, 1871-1946, 324 (Nov.)

Henslee, Samuel Clifford, 1870-1946, 349 (Dec.)

Jennings, Douglas, 1894-1946, 350 (Dec.)

Keisler, David S., 1878-1946, 146 (May)

Lucas, Simons Ravenel, 1885-1946, 324 (Nov.)

Lynch, William S., ?-1945, 20 (Jan.)

Montgomery, Benton McQueen, 1888-1946, 146 (May)

Routh, F. M., 1885-1946, 292 (Oct.)

Rutledge, James Andrew, 1862-1946, 178 (June)

Scarborough, Henry L., ?-1945, 20 (Jan.)

Seibels, Robert Emmet, Jr., 1918-1946, 207 (July)

Speissegger, Charles A., 1881-1946, 207 (July)

Stith, Robert Boyd, 1886-1946, 82 (March)

Stroud, Edward Clayton, 1875-1946, 324 (Nov.)

Ward, James Luther, 1879-1946, 178 (June)

Wilson, Robert, 1867-1946, 175 (June)

Workman, Henry Herbert, ?-1946, 324 (Nov.)

Zimmerman, W. S., 1884-1946, 292 (Oct.)

E

Exchange department

Emergencies of the neonatal period, 61 (March)

Penicillin in obstetrics, 65 (March)

Observations on the etiology, pathology, and symptomatology of poliomyelitis with special consideration of dehydration treatment of poliomyelitis, 88 (April)

EDITORIALS

A century old, 67 (March)

A decision must be made, 38 (Feb.)

A word of thanks, 195 (July)

Anderson County memorial hospital, 250 (Sept.)

Annual meeting, 336 (Dec.)

Annual meeting of S. C. medical association, 67 (March)

Blue Cross in action, 38 (Feb.)

Catching up, 222 (Aug.)

Compulsory blood tests, 177 (June)

Congratulations, 279 (Oct.)

Dr. Robert Wilson, 175 (June)

Exchange department, 67 (March)

Greenville hospitality, 94 (April)

Heart disease and tuberculosis, 307 (Nov.)

Hiroshima and Bethlehem, 335 (Dec.)

Hospitals, 336 (Dec.)

House of delegates meeting American medical association, 251 (Sept.)

In Chicago, 9 (Jan.)

In St. Louis, 38 (Feb.)

James Adams Hayne, 39 (Feb.)

Maternal and child welfare bill under consideration, 201 (July)

Medical care for veterans, 194 (July)

Members of Congress, 67 (March)

Memorial resolutions on Robert Wilson, M. D., 195 (July)

Myrtle Beach, 96 (April)
 New blood, 336 (Dec.)
 Our guest speakers, 96 (April)
 Our leaders, 96 (April)
 Our membership, 280 (Oct.)
 Our new president, 123 (May)
 Our new vice-president, 176 (June)
 Our 1947 meeting, 279 (Oct.)
 Our president-elect, 123 (May)
 Pediatric seminar, 124 (May)
 Postgraduate seminar, 177 (June)
 Postgraduate seminar, 194 (July)
 Post-War questionnaire, 336 (Dec.)
 Procurement and assignment, 124 (May)
 Progress of the S. C. child health study, 222 (Aug.)
 Recognition, 280 (Oct.)
 Southern medical, 177 (June)
 State meeting program, 38 (Feb.)
 Study of child health services, 124 (May)
 The annual directory, 222 (Aug.)
 The annual meeting, 94 (April)
 The annual postgraduate seminar of the alumni association will be held in Charleston, Nov. 5, 6, and 7, 1946, 125 (May)
 The directory, 280 (Oct.)
 The hospital survey, 279 (Oct.)
 The Rh factor, 250 (Sept.)
 The San Francisco convention, 223 (Aug.)
 What have we done? 307 (Nov.)
 What shall we do? 39 (Feb.)

F

Foot, disabilities of, (F. A. Hoshall), 117 (May)

G

Gall bladder disease, the medical treatment of, (John A. Boone), 272 (Oct.)

H

Hemothorax, the treatment of and its complications in thoracic injuries, (Edward F. Parker and Thomas H. Burford), 325 (Dec.)

Histamine compound, the use of in the treatment of infantile eczema, (George D. Johnson), 29 (Feb.)

I

Intestinal obstruction, (George E. Thompson), 295 (Nov.)

Jaundice, helpful considerations in diagnosis of surgical cases of, (Marion L. Mathias), 115 (May)

M

Medical College of the State of S. C., program of fifth annual postgraduate seminar alumni association, 308, 309 (Nov.)

Medical dilemma, a commentator's view of, (Upton Close), 302 (Nov.)

Medical education in South Carolina, 53 (March)

N

National health program message from the president of the United States, 31 (Feb.)

Nutritional status, of the people of South Carolina, (Julian P. Price), 186 (July)

News items, 26 (Jan.); 48 (Feb.); 78 (March); 106 (April); 134 (May); 178 (June); 202 (July); 232 (Aug.); 264 (Sept.); 291 (Oct.); 318 (Nov.); 348 (Dec.)

O

Obesity, in general practice, (Wm. T. Hendrix), 332 (Dec.)

Obstetrical patients, practical suggestions for the care of, (Arthur L. Rivers), 298 (Nov.)

Omentum, primary cysts of the, (D. L. Maguire and A. J. Buist), 2 (Jan.)

Organic obstructive vascular disease, sympathetic nerve interruption in the treatment of, (H. G. Smithy), 241 (Sept.)

Our advertisers, 311 (Nov.)

P

Pediatrics, hot weather, (J. I. Waring), 211 (Aug.)

Piedmont postgraduate assembly, program of eleventh annual clinical assembly, 240 (Aug.)

Post hoc sed non propter hoc, (R. M. Pollitzer), 330 (Dec.)

Proctologic conditions, some common of childhood, (Louis J. Hirschman), 267 (Oct.)

Public health news, 22 (Jan.); 50 (Feb.); 80 (March); 138 (May); 204 (July); 234 (Aug.); 288 (Oct.); 320 (Nov.); 344 (Dec.)

Public health, the politician, and the doctor, (Lowell S. Goin), 274 (Oct.)

Pyelocystostomy, in an infant, (Roger A. Way, George D. Johnson, Furman T. Wallace), 246 (Sept.)

R

Remarks and announcements, (Kenneth M. Lynch), 305 (Nov.)

Rheumatic fever program in S. C., submitted by staff of the rheumatic fever program, 150 (June)

S

South Carolina medical association, address of president-elect, (James McLeod), 147 (June)
 annual meeting of, 67 (March)

annual meeting of house of delegates, 157 (June)

annual meeting, program, 85 (April)

balance sheet, 69 (March)

meeting of council, 310 (Nov.)

officers, 1945-1946, 52 (Feb.); 84 (March); 92 (April)

officers, 1946-1947, 208 (July); 323 (Nov.)
 president's address (W. Thomas Brockman),
 120 (May)
 report of the memorial committee annual ses-
 sion, 221 (Aug.)
 special meeting of the house of delegates, 34
 (Feb.)
 statement of cash receipts and disbursements,
 68 (March)
 ten point program, statement of receipts and
 disbursements, 69 (March)
 the 1947 meeting of, 279 (Oct.)
 South Caroliniana, 142 (May)
 Southern pediatric seminar, 107 (April); 135
 (May)
 Statement issued by S. C. state board of health,
 91 (April)

SOCIETIES

Abbeville county, meeting, 110 (April)
 Chester county, meeting, 108 (April)
 Chester county medical society, meeting, 134
 (May)
 Chester county medical society, meeting, 178
 (June)
 South Carolina public health association, annual
 meeting, 122 (May)

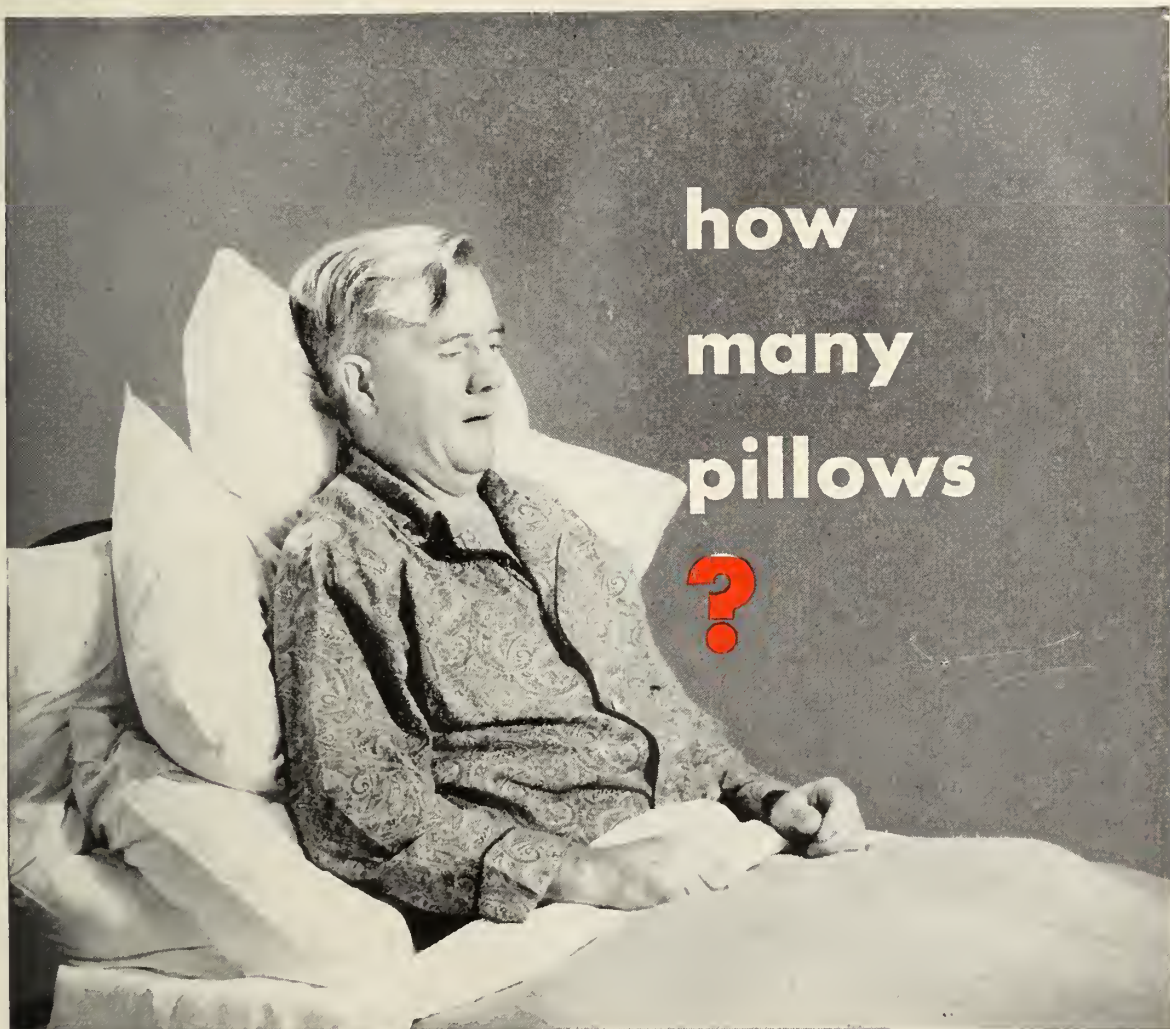
T

Thyroidectomy, some technical considerations in,
 (Furman T. Wallace), 248 (Sept.)
 Ten point program
 a health service system for the future, 338
 (Dec.)
 a year for action, 40 (Feb.)
 a doctor, reviews the Wagner bill, 70 (March)
 accentuate the positive, 42 (Feb.)
 an experiment fails, 318 (Nov.)
 another view on public relations, 44 (Feb.)
 Christmas, 1946, 337 (Dec.)
 committee on medical college completes work,
 14 (Jan.)
 committee works on relocation problem, 46
 (Feb.)
 conference on prepaid medical insurance, 11
 (Jan.)
 council states position on pending bill, 96
 (April)
 democracy and medicine, 230 (Aug.)
 doctors and politics, 337 (Dec.)
 Dr. Price to address presidents' conference in
 San Francisco, 201 (July)
 editorial opinion re president's health insurance
 proposal, 76 (March)
 educational program conducted on national
 health bill, 100 (April)
 general assembly receives expansion program,
 70 (March)

governor signs blue cross act, 39 (Feb.)
 hearings set on Wagner-Murray-Dingell bill,
 70 (March)
 highlights of the national health bill of 1945,
 97 (April)
 how South Carolina ranks, 314 (Nov.)
 labor's new approach, 280 (Oct.)
 malignancy—should the patient be told? 232
 (Aug.)
 medical prepayment plan next, 224 (Aug.)
 national health congress proposed, 16 (Jan.)
 new provisions for maternal and child health
 services, 229 (Aug.)
 not time for the jitters, 44 (Feb.)
 on solving the problem of health, 312 (Nov.)
 pending bills, 40 (Feb.)
 plans underway for veteran's care, 97 (April)
 politics and medicine, 254 (Sept.)
 prepaid medical insurance on a national vol-
 untary basis, 18 (Jan.)
 private health insurance, 344 (Dec.)
 proposed plan for a national association of
 medical service plans, 18 (Jan.)
 public health, politics and medicine, 281 (Oct.)
 recommendations as to prepayment medical
 care plan, 74 (March)
 report of the special committee of the confer-
 ence on voluntary prepayment medical care
 plans, 12 (Jan.)
 reputation commensurate with character, 42
 (Feb.)
 rural medical care, 228 (Aug.)
 St. Louis conference, 284 (Oct.)
 state control of disability benefits, 342 (Dec.)
 suggested standards of acceptance for medical
 care plans, 72 (March)
 summary of suggestions made at conference,
 14 (Jan.)
 support the veterans' care program, 294 (Oct.)
 the end of S.1606, 252 (Sept.)
 the farmer and compulsory health insurance,
 286 (Oct.)
 the president and the Wagner-Murray-Dingell
 bill, 254 (Sept.)
 the prevalence of polls, 74 (March)
 the record of Congress in social security (1946),
 340 (Dec.)
 the Taft health bill, 196 (July)
 veterans' care, 132 (May)
 what labor expects from medicine, 125 (May)
 why have a conference of presidents? 256
 (Sept.)

W

Woman's auxiliary, 46 (Feb.); 110 (April); 180
 (June); 292 (Oct.); 322 (Nov.); 346 (Dec.)



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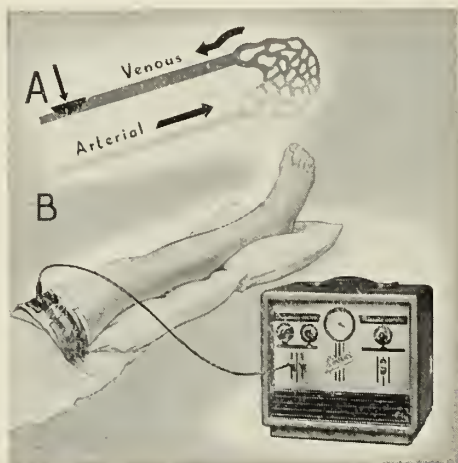
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SHALL STRIVE WITH INCREASING
EARNESTNESS TO MEET
OUR RESPONSIBILITIES TO
THOSE WHO HAVE PROVIDED
OUR OPPORTUNITIES.

TOGETHER WITH THIS
PLEDGE WE EXTEND TO YOU
OUR HOLIDAY GREETING AND
OUR WISH THAT YOURS MAY
BE A VERY MERRY CHRISTMAS
AND A HAPPY NEW YEAR.



Wm. H. ... TRUSTEE
Wm. H. ... PRESIDENT
Wm. H. ... VICE PRESIDENT & TREASURER

American  Optical
COMPANY

